“Breast is Best”, though it “takes a village to raise a child”

PROJECT PLAN
June 2018

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Child Public Health Team
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What are we trying to achieve?

We are trying to reduce the number of small babies in A&E who would be better served being seen in a different environment. We are aware that we have a large number of babies coming to A&E at NWPH who have diagnoses that appear to relate to feeding problems, or otherwise well babies with parental concerns.

In light of this, we are trying to look ‘upstream’ to where the problems are arising that result in parents seeking advice in A&E. We plan to survey our local parents in order to process map their feeding journeys with a young baby, and learn why some come to A&E. We want parents to know more about breast feeding (part of UNICEF Baby friendly initiative – we are accredited); know where to go if they have a problem (part of Baby friendly initiative); get the right advice and treatment when they do attend those services; and ensure our staff attitudes promote and support breast feeding as the best nutrition for mother and baby.

We already know that 1060 babies came to A&E in 2017 under 28days old, over 60% had a “well-baby” or feeding related diagnosis. We think it is possible to reduce the amount of babies attending with a better understanding of our local system and a few evidence-based measures put in place.

SMART AIM:
To reduce the number and rate of <28 day olds coming to our Emergency Department with an avoidable feeding problem or “well baby” diagnosis by 10% over 6 months

Why is it important?:

Seeing 2-3 babies a day that “don’t need to be in A&E” not only a costs clinician time and the service money, but we are aware that the management of these babies is not always optimal. This has an ongoing impact on breastfeeding rates and subsequent health problems related to this (breast feeding mothers who stop before they wanted to have 2x rates of PN depression. Costs of admissions for childhood infections that BF babies are less likely to have. Maternal cancer rates etc – see UNICEF document [1])

Making a defined and concerted effort to improve our local feeding support uptake, and improving our staff training and attitudes when parents do present (and on PNW, maternity, ante-natally etc) means ongoing benefits for staff, families and the community. There is not only an economic health advantage, but also an environmental saving, well-being improvement and better bonding and attachment. The evidence now also shows increased intelligence, meaning our local community will produce children who can go on to achieve more, contributing more to the economy in the future.

This project also is in keeping with key strategic aims of LNWUH NHS Trust. Reducing childhood obesity is a core aim for the trust, and it is shown that breast-fed babies are less likely to be obese children and adults[2]. Starting good nutrition from birth is an important element of this key aim.

This aim is in keeping with the RCPCH position statement on breastfeeding (Nov 2017)[5] that paediatricians and practitioners should not undermine breastfeeding mothers and the success of breastfeeding. It also calls for more work on improving the social and cultural factors behind the UKs poor breastfeeding rates – in our small way, we will contribute to this locally.

How will we know a change is an improvement?

Once we have determined our plan for change (action effect diagrams – in process currently) we will implement our new practices. We would then review the data from A&E monthly using the Symphony ED information system. So far our timeline is in keeping with an October initiation date.

With regard to breast feeding rates, this data collection is usually done by community midwives at discharge, 10-14 days and health visitors/GPs at 6-8 week check. This is currently collected as part of health visitor local KPIs on CHIS.

What are our outcome, process and balancing measures?

Outcome measure – avoidable A&E attendances (pre-defined) , staff knowledge and attitudes (pre and post intervention surveys) changes to parental experiences (pre /post survey response categorisation) , % of mothers who have maintained breast feeding at 6-8 weeks check

Process measures –,% of breast feeding mothers using community infant feeding support services ,

Balancing measures – staff and parental experiences (pre /post survey response categorisation), increases in HV and GP workload related to feeding issues (informal feedback surveys, contact to project lead)

These will be reviewed and adjusted as part of our QI development bi-weekly meetings with QI expertise support. (provided by our collaboration with CLAHRC NWL (Collaboration for leadership in Applied Health Research and Care NorthWest London))

What changes could we make?

Current ideas for changes are:

1) introducing a proactive motivational text message service after discharge to community from maternity services. In keeping with current local plans and known to be deliverable on trial basis. The current evidence of best practice shows proactive breastfeeding support is most effective[3]
2) increasing & adjusting staff training (particularly doctors and A&E staff) about benefits and basics of breast feeding and clear practical advice about support services in the area
3) better signposting of parents to sources of information and support (Facebook group 'start4life'; local BF clinics etc)

These are for review during upcoming project development meetings and will be co-designed with parents and both hospital and community staff to ensure sustainability and better tailoring for our local population.

Why do we need funding?

Our funding application covers two main areas: Staff time and estimated costs of proposed design sessions and interventions.

QI projects are becoming a more common way to approach 'problems' within the healthcare setting. Success in both development of ideas, implementation and sustainability of change is dependent on stakeholder engagement. We know from our local feedback that finding time and cover, particularly for clinical roles (where there can be less autonomy over time and flexibility in the working day), to be able to actively participate in these projects can be a major barrier to stakeholder involvement and subsequent project success. Therefore, we have budgeted to provide locus cover for staff to be able to attend regular meetings for project development and initial implementation. We would then look to embed any extra training (one of the suggested interventions) into job plans for staff at the trust in order to sustain this intervention.

Many parents can struggle to attend events, particularly at the hospital, due to time and travel costs. We have therefore allocated budget to support parents travel costs in order to allow their participation, and show we appreciate their efforts. Co-design events will have creche facilities to enable parents to focus on the event as they would like, but still attend if they have their children.

Costs for co-design events we would hope do not need to be regular; though we would look for further funding for this in the future if required beyond the Q exchange funding period.

Costs for implementation are estimated and will be adjusted as further project development continues. As discussed later, once implementation has started, a full business plan for continued intervention will be created, supported by monthly data from the Q exchange project to enable long term continuation.

Who are our stakeholders?

Our stakeholders are local parents; health visiting; local authority child health; women and children's directorate management; maternity management; paediatric division leads; infant feeding advisors, hospital and community; junior doctors; A&E nurses; data analysts; CCG; local GPs; Infant Feeding educators; obstetric and paediatric clinical leads; administrative staff hospital and community (children centres); IT; quality improvement; clinical governance

How will we keep them engaged?

First full stakeholders meeting 5th July with refreshments. We will define commitment from each group and ask them to sign up to project on first day. To nominate proxy in case of being unable to attend future meeting. Address the stakeholders concerns and expectations. Project plan together. Personalities and working type review after first meeting by project leads to ensure messaging is tailored appropriately. Focused discussions with each group according to their needs.

Collaboration within Q community

We have been in contact with the Q team from Morecombe Bay, (Amanda Adams and co) about sharing data about staff attitudes and learning as well as discussing the development of materials for staff education and teaching programmes. We await further progression of their work, and will happily contribute to their project as requested.

What are the risks?

Risk	Mitigation
Poor Stakeholder engagement	- involve key individuals and map stakeholders - clear timeframes of involvement from stakeholders - administrative support to co-ordinate meetings and deadlines - Key managers (clinical and non-clinical) are already aware of project and are in agreement for continuation.
Maintaining sustainability	- Long term success QI tool - Management support - Maintain changes by embedding - Stakeholder engagement work - Plan for future budgets - business plan with live data after implementation - “prove it’s worth the money”
Complaints from patients	- All complaints directed immediately to senior – Mitch Blair - Involve patient engagement team and ensure support of QI governance team before patient engagement. - Actively involve from as early in project as possible
QI skills variable among team members	- CLAHRC relationship to enhance QI knowledge and support design of ideas - Online learning - Support of Q community

What are our next steps?

1) This month **Exploration** continues:
    a. Continue to establish what services are available currently
    b. Survey of doctors in A&E and PNW about attitudes and knowledge of breast feeding – approval granted and should be sent out this week (based on Freed etc al surveys from 1990s in USA [4]- allowing comparison)
        i. Survey for midwifes and A&E nurses as well
    c. Interviews of parents using breast feeding support services and their ‘journey’ so far – local governance proportionate review/approval sought

   d. Determine how to assess parents not accessing services – potential to interview parents (non clinical interviewer) in A&E who are using services? Goernance approval will be required
   e. Data: agreement score for diagnoses meaning well baby or feeding problem for standardisation of data analysis
2) QI tools with help of CLAHRC NWL (Collaboration for leadership in Applied Health Research and Care NorthWest London) -**Design and Development JULY/AUG/SEPT**:
   1) stakeholder mapping;
   2) process mapping;
   3) action effect methods;
   4) measurement design and development;
   5) co-design of interventions;
   6) sustainability;
   7) collaboration with other Q members – such as Morecombe bay for supportive data sets, developmental ideas
3) **implementation October;**
4) Data analysis – PDSA cycles – monthly as data sets arrive
5) Sustainability, review & learning – both within local teams and to wider Q community

For further details, please see appendices below:

SUMMARY:

Project delivery will be done using QI tools. Our in-depth QI strategy can be found on the idea website. In order to ensure project delivery in the estimated time frame (Exploration - June/July; Design - August/September; Implementation – Oct/March) we are collaborating with the CLAHRC NWL team to enhance our QI skills and support. This will have a number of stages, across bi-weekly meetings of key stakeholders jointly identifying and working through actions. Milestones during development will be stakeholder mapping; process mapping; action effect methods; measurement design and development; co-design of interventions; sustainability; implementation; review & learning.

Whilst following the logical sequalae of these QI methods, we are aware that flexibility within our scope and development stage (such as engaging previously unidentified stakeholders) is more likely to ensure the correct people are involved in the project, subsequently enhancing both the idea development, likelihood of successful implementation and further sustainability of our work.

Our approach is to use and enhance our skills and services within the team, thereby allowing people to work within their areas of strength, whilst developing through experiencing the expertise of their colleagues on this project. Alongside regular review of progress and development of the project, in this way we can ensure a positive progression through our plan. With the outside overview of CLAHRC, there will be accountability within the work – further enhanced by the level of by-in which we have had so far from our stakeholders, thereby increasing our chances of successful project delivery.

Reference for this document:

1. Renfrew MJ, Pokhrel et al. Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK. UNICEF UK. Oct 2012
2. . Victoria. C, Bahl. R, et al. Breastfeeding 1: Breastfeeding in the 21st century: epidemiology, mechanism and lifelong effect. 2016 Lancet 387:475-490
3. Rollins N, Bhandari N et al. Breastfeeding 2: Why invest, and what will it take to improve breastfeeding practices. Lancet 2016
4. G Freed et al; National assessment of physicians' breast-feeding knowledge, attitudes, training, and experience JAMA. 1995 Feb 8;273(6):472-6.
5. RCPCH position statement November 2017 https://www.rcpch.ac.uk/resources/position-statement-breastfeeding-uk

Appendix 1: SWOT analysis

"Breast is Best" but it "takes a village" to raise a child

SWOT analysis of project as of 17.06.18

See risk review in AIMS application for mitigation

<table>
<tr><th>Strengths</th><th>Weaknesses</th></tr>
<tr><td>Local support of QI methodology through Q community and CLAHRC
Fits with trust strategy to reduce childhood obesity
Good initial engagement from stakeholders
Clear data showing extent of 'problem' in A&E fitting with staff narrative
Engaging idea – better to be seen in community than A&E with 'well baby'
Enthusiastic infant feeding leads already investigating changes within local community</td><td>Community and hospital based – now under different providers, risk of loss of stakeholder engagement – co-ordination is key
Multi-team dependent across clinical and managerial teams (requires strong stakeholder engagement)</td></tr>
<tr><th>Opportunities</th><th>Threats</th></tr>
<tr><td>Build community links between children's centres and local charities (La Leche League, NCT etc)
Improve patient experience when attending A&E
Help parents navigate services after childbirth more easily
Improve staff confidence and understanding of normal baby behaviour and breast feeding
Improve coordination of different NHS teams involved in mother and baby care across the trust and local community
Increase number of women and babies breastfeeding – and subsequent health, economic, environmental, well-being and bonding benefits</td><td>Possible lack of funding to support implementation of changes
Possible lack of funding to continue improvements if initial funding application successful
Possible practical difficulties in cross-site implementation
Possibility of Poor interview and survey response from parents and doctors
Low parent involvement due to unrecognised factors
Competing priorities for stakeholders</td></tr>
</table>

Appendix 2: Timeline of project

"Breast is Best", thought it "take a village" to raise a child

Time line

EXPLORATORY MAY-JULY

- Training already done for staff (BFI and other) (and dates upcoming training is occurring)
- Resources EDUCATIONAL & INFORMATIONAL
  - What's available for staff
    - In hospital
    - In community
    - Communication between staff for resrouces etc
  - What's available for mothers
    - Facebook groups etc
    - Local charity services
    - Children' centre
    - In hospital
- Interviews
  - Parents
  - IFN
  - Health professionals
- Literature review
  - What's already out there that works?
  - Bounty packs – what's in them and
    - what do we give out in our own discharge packs?
- Data
  - Who's coming to A&E?
    - What are they coming with?
    - Any common factors in the babes (parity, postcode, deprivation, feed type etc)
  - Survey results
- **Start first large stakeholder meetings to develop process mapping and action effect methods**

DESIGN JULY-SEPT

- Bi-weekly QI/ meetings with relevant stakeholders
- QI methodology
  - stakeholder mapping; process mapping; action effect methods; measurement design and development; co-design of interventions; sustainability; implementation; review & learning.
- Prioritisation of interventions likely - EDUCATIONAL AND INFOMRATIONAL
  - Motivation to complete
  - Practicalities to complete

IMPLEMENTATION OCT -

- Put in place intervention/s

REVIEW ongoing –

- **Ongoing data collection in time series post intervention**
- **PDSA cycles monthly**

MARCH/APRIL

- Collate results and continue with intervention if successful
- Review learning from project
- Share learning and results with colleagues and Q community
- Establish business plan if ideas dependent on ongoing funding for presentation to relevant stakeholders. (who will be aware from initial and regular meetings and updates)

Appendix 3: QI methodology

"Breast is Best", though it "takes a village" to raise a child

Project Plan notes:

Using QI methods to their best effect:

Team Members and Outline of commitments: The project manager will coordinate a series of regular meetings throughout the project for the core representative project team inclusive of: the clinical leads; parents from two local boroughs; QI support from CLAHRC NWL (Collaboration for Leadership in Applied Health Research and Care Northwest London); infant feeding teams; midwives; ED consultant & project sponsor; junior doctors; local authority health team; clinical managers; administrative staff; IT support staff; and further QI/ R&D staff. The purpose of these meetings is to gain engagement of the key stakeholders, to gain consensus regarding the project plan and to collaboratively identify and work through actions. The aim is for alternate weekly project team meetings to be attended by the relevant core project team members dependent on the phase of the project. This both maintains momentum regarding the project aims and allows enough time for actions to be explored/ completed before the next meeting.

Developing robust QI skills and knowledge: The first significant step is the introduction of the CLAHRC systematic approach encompassing a suite of QI methods, which will help structure the project and support demonstration of improvement overtime. The CLAHRC team have worked on a number of QI projects at London Northwest NHS trust and have generously supported the project with their expertise. Through the collaboration with CLAHRC, it is envisaged that core team members, inclusive of parents, will gain an understanding of QI methods.

Stakeholder Mapping: They will be guided in the development of stakeholder mapping to ensure that people interested in and who will influence the project are included and that the engagement and communication plans consider how best and when to involve these people/ groups.

Process Mapping: It will be important to understand current staffing/ service relationships along the pathway from the parents' interaction with antenatal services through to post-natal ward staff, health visitors and community services. This is a useful tool to help understand current services and pathways. Once mapped a higher-level future-state map can be developed by the project team giving clarification regarding their ideas for interventions and how they view the future service.

Action Effect Methods: Once the project team and wider stakeholders understand the current service and pathways and ideally have data relating to the current healthcare problem it is useful to plan an action effect method session. This technique, again facilitated by the CLAHRC team, supports the development of an Action Effect diagram. This diagram is inclusive of an over-arching aim developed and thus shared by the participants. This process helps clarify the major factors, which contribute to the achievement of the aim and includes cause and effect chains linking ideas for implementation with the aim. The diagram gives an overview of the project and a useful tool to help the project team and wider stakeholders to communicate their ideas with people (stakeholders) both interested in and who influence the project. Further measure concepts re: outcome, process and balancing measures can be

plotted onto the diagram.

Measurements: Process measures need to be clearly defined. The information analysts and improvement science manager will support the team to review what data they already hold, access to this data and what needs to be measured to demonstrate improvement in relation to interventions that will be implemented. Recording of agreed measures on a regular basis (often daily/ weekly) is needed for the development of statistical control charts, which will be used to demonstrate improvement overtime.

Sustainability: During the course of the project at agreed project team meetings the team will use the Long Term Success Tool. This method allows each team member to record their scores and draft comments against 12 factors within the 3 categories of: People; Practice; Setting. This tool not only supports people to express their ideas, but anonymised reports can help the team discuss and plans actions to mitigate against challenges they might experience.

Review & learning: It is envisaged that a final review (6 month) meeting will be held by project team members to review the project aim, data and what has been achieved. It is also an opportunity to discuss the challenges encountered and what might affect sustainability. A Long Term Success Tool report (spider diagram) demonstrating how the results, including anonymised comments, change through the life of the project can be useful in highlighting and areas of challenge that might hinder future embedding of the changes that have been tested and implemented.

We feel that this structure of QI tools, alongside other examples, such as Plan-Study-Act-Do cycles, enables us to create a strong and sustainable project that can improve the experience of parents, outcomes for our local families, and staff experience and training.

The experience we gain, and skills developed will be further disseminated throughout the Trust to ensure other projects and ideas can have future success at London NorthWest University NHS Trust.

Appendix 4: References used in AIMS application

“Breast is best”, though it “takes a village” to raise a child

AIMS application references:

UNICEF

6. Renfrew MJ, Pokhrel et al. Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK. UNICEF UK. Oct 2012

Lancet 2016:

7. . Victoria. C, Bahl. R, et al. Breastfeeding 1: Breastfeeding in the 21st century: epidemiology, mechanism and lifelong effect. 2016 Lancet 387:475-490
8. Rollins N, Bhandari N et al. Breastfeeding 2: Why invest, and what will it take to improve breastfeeding practices. Lancet 2016

The Nuffield Trust:

Ronny Cheung, Research Report March 2018; International comparisons of health and wellbeing in early childhood, The Nuffield Trust in association with RCPCH

The Point of Care foundation:

Evidence regarding co-design with staff and patient - https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/step-by-step-guide/2-experience-based-co-design/

Physician Attitude:

1. Fiona Dykes, The education of health practitioners supporting breastfeeding women: time for critical reflection. Maternal and Child Nutrition 2006. Vol 2 4: 204-216
2. Cleminson J, Oddie S, Renfrew MJ et al. Arch Dis Child Fetal Neontal Ed 2015; 100:F173-F178
3. G Freed et al; National assessment of physicians' breast-feeding knowledge, attitudes, training, and experience JAMA. 1995 Feb 8;273(6):472-6.

Costs

https://www.rcn.org.uk/employment-and-pay/nhs-pay-scales-2017-18