Recommendations and actions – attributes most associated with system improvement

from the New Zealand Child and Youth Mortality Review Committee – *Nick Baker and Brandy Griffin*

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Kupu Taurangi Hauora o Aotearoa

newzealand.govt.nz

Child and Youth Mortality Review Committee

'To identify, address and potentially decrease the numbers of infant, child and youth deaths in New Zealand'

The New Zealand Child and Youth Mortality Review Committee (CYMRC) was established in 2002. It is a statutory committee, accountable to the Health Quality & Safety Commission. During its initial years, the CYMRC focused on gathering information. The focus has now moved to making recommendations and supporting system improvement. In this poster, we explore the attributes and preventive potential of recommendations and the associated actions, aiming to identify those most likely to result in system improvement.

A. INFORMATION TO FUEL THE MACHINERY OF CHANGE

The CYMRC reports data and makes recommendations. Local CYMRC groups work in their communities to support inter-sector review and system improvement.

THE CYMRC'S ROLE

- ✔ Know of deaths
- ✔ Collect information
- ✔ Sort and organise
- ✔ Analyse
- ✔ Develop recommendations
- ✔ Advocate, influence and promote action
- ✔ Less mortality and morbidity?

The CYMRC has established multi-sector groups in every district health board (DHB). They function to review local deaths and improve local systems to make deaths less likely.

2002 – set up systems to collect data

2003 – data collection and collation set up on a single national database

2005 – local review pilots in two DHBs

2008 – local review established in 11 DHBs, with funding to support local review in all DHBs and a national coordinator

2009 – local review established in 15 DHBs, the CYMRC developing chapters on specific causes of death and themes

2010 – local review established in 20 DHBs

2012 – focus on quality and consistency, and strengthening local review

Figure 1: Implementation of recommendations by CYMRC report

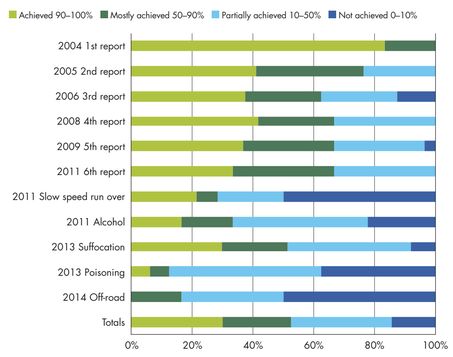
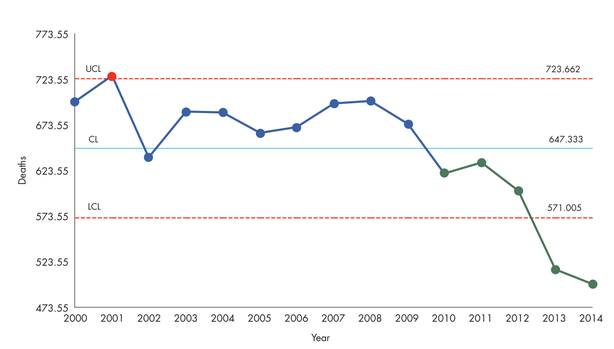


Figure 2: Decreasing New Zealand child and youth deaths, 2000–14



Since its formation, the CYMRC has made 202 recommendations in reports published nationally.
Figure 1 shows the extent to which these recommendations have been implemented and resulted in preventive action and system improvement (based on evidence from experts, policy documents and interviews with key staff).

Recommendations from more recent reports have been implemented to a lesser extent. This is important for two reasons:

1. It demonstrates that a well-developed recommendation may still require a considerable amount of promotion and advocacy in order to be fully achieved. The time and resource required for such promotion and advocacy must be planned.
2. For recommendations that focus on areas over which the health sector has less influence, it is harder to achieve high levels of implementation. This suggests more effort may be required to grow greater influence outside the health sector.

B. AN EXAMPLE – PREVENTING SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

Detailed information allowed the CYMRC to recognise that suffocation in place of sleep is a major component of SUDI (see Figure 3). The unexpected nature of these deaths can lead to an acceptance that these deaths 'just happen', with families left feeling disempowered. Families have the 'right to know' the facts and be:

- empowered by knowledge of the circumstances in which suffocation occurs
- supported in having safe environments for infant sleep.

Figure 3: Mortality (%) in infants aged 28 days to <1 year, New Zealand, 2006–10 (n=683)

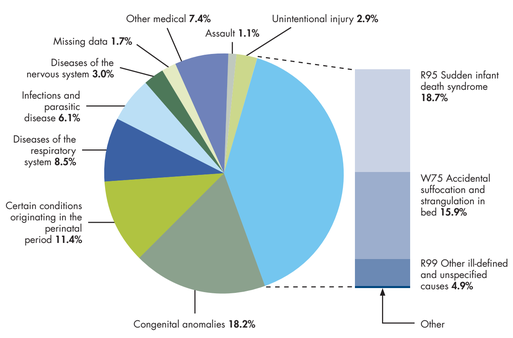
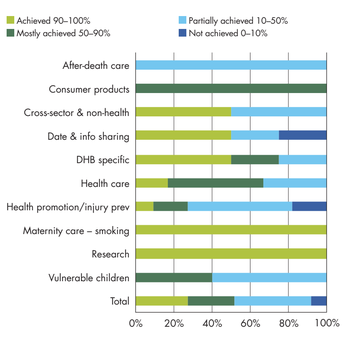


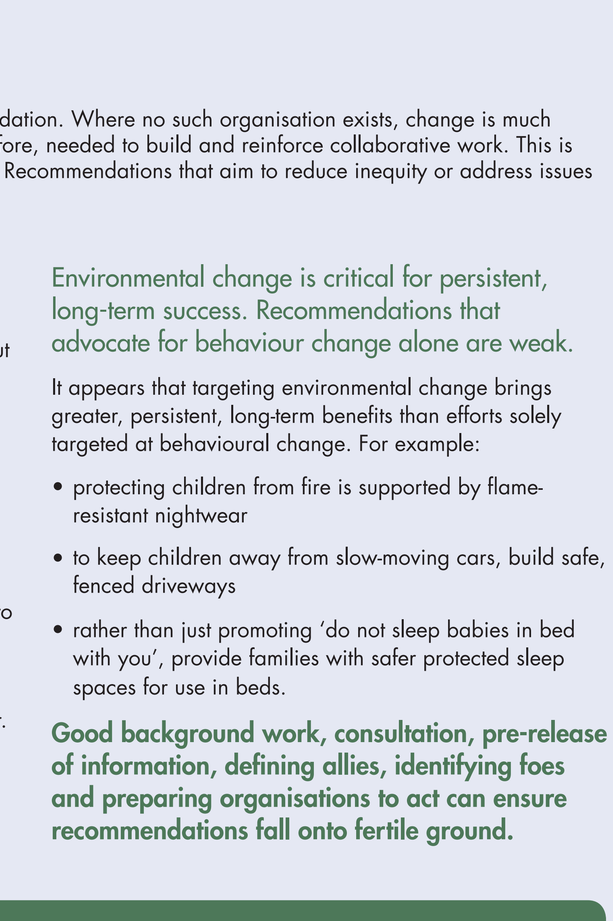
Figure 4: Implementation of recommendations from the CYMRC suffocation report (2013) by theme



Consistent and persistent safe sleep practices

- Māori, community-driven solutions:
  - Culturally appropriate, appealing, possible and easy.
- Safe sleep for infants reprioritised:
  - Model and support good practice at every opportunity, especially during health care. Staff must be trained and DHBs need a policy and must audit and keep records.
  - Prepare during the antenatal period.
  - Enable safe sleep. Wahakura and pepi-pods might make doing the right thing easy, as we did with car seats.
  - Make safe sleep a whole-of-society priority from schools to great grandparents!
- Every baby needs a sober caregiver.

Fewer infants died in Christchurch in the one year post-earthquake than in previous years.



'More risk' to babies after earthquake

GILES BROWN

Last updated 05:00 23/03/2011

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SAFE: Penerith Tuiloma uses a pepi-pod, a small fabric cot, for her one-month old baby, Ritesiya, to sleep safely in her bed alongside Arina, who is a year old. Ritesiya was born on February 22, the day of the earthquake.

Babies are at greater risk of dying as living conditions change in Christchurch, a paediatrician says.

Child and Youth Mortality Review Committee chairman Nick Baker said the risk of infants dying from asphyxiation had increased after last month's quake.

A major concern was exhausted parents falling asleep on children, especially if they were seeking a feeling of security by using the same bed. Makeshift sleeping arrangements on beanbags or mattresses were also dangerous.

Babies could roll over on beanbags and suffocate, or get trapped between mattresses and walls.

Baker said one way of reducing risk was to use a pepi-pod, a small fabric cot.

A Christchurch organisation, Change for our Children, wants to collect 1000 pepi-pods to give to city families.

Penerith Tuiloma, 25, who was given a pepi-pod this week, said she had been sleeping alongside her daughter, Ritesiya, since she was born on the day of the quake.

Tuiloma said Ritesiya slept well in the pepi-pod and she could still keep her baby safely by her.

"We need to sleep together with my kids. I'll sleep with them until the earthquakes finish," she said.

Change for our Children director Stephanie Cowan appealed to the public to sew covers for sheets and donate fabric and merino wool for the pods.

They should also alert the organisation to families in need.

"It would be a tragedy to have got through the earthquake and then die this kind of death," Cowan said.

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Christchurch earthquake
- EQC faces court challenge over repair policies
- Young Cantabrians to have their say in shaping of Christchurch
- Late, inadequate and frequently defective
- 'Inquisitive' duo caught inside Christ Church Cathedral
- Greendale residents smash pianos in earthquake memorial
- Rodents and rot: Canterbury Provincial Chambers a long-term fix
- Kaiapoi five years on: Living on the edge
- Hororata businesses find life tough after earthquake
- The big question: is the shaking over for Canterbury?

Source: www.stuff.co.nz/national/christchurch-earthquake/4798192/More-risk-to-babies-after-earthquake

C. ATTRIBUTES OF RECOMMENDATIONS THAT ARE MORE LIKELY TO BE IMPLEMENTED

Successful recommendations typically have a precise, actionable component and an agency or organisation that is primed and motivated to follow through on achieving the recommendation. Where no such organisation exists, change is much harder. In the areas of slow speed run over, poisoning and off-road vehicle deaths, the contributory factors do not lie under the influence of a single sector. Considerable effort is, therefore, needed to build and reinforce collaborative work. This is most effective if driven by clear information and shared values. Persistence by many over time can result in system change, as is beginning to occur in the area of alcohol-related harm. Recommendations that aim to reduce inequity or address issues related to vulnerable children typically require influence across many sectors to leverage change.

Traits of recommendations that are successfully implemented include the following:

- Clear problem identification directed to a single body that must develop a response – this includes recommendation to the CYMRC, with regard to its own actions and system.
- Clearly implementable solutions to be implemented by a single body, eg, trading standards and pyjama fire safety labelling.
- A suite of actions directed to several organisations to be implemented simultaneously.
- Framed to appeal to values that are shared across the intended audience:
  - Safe sleep to prevent infant suffocation.
  - Parents have a right to know.
  - Right balance of closeness and safety.
  - Supporting infant survival.
- Directed to strong allies that can 'plug' into an existing 'machine', eg, Safekids Aotearoa was working on driveway run over; the CYMRC data supported its work.
- Backed by effective networking that has cultivated allies throughout the process, eg, the CYMRC shared its data early on in the reviews of the alcohol and transport legislation.
- Aligned with current government programmes, eg, the Ministry of Health's work on newborn enrolment.
- Developed collaboratively.
- Support recommendations already made by others or have others who echo the recommendations (as in Coronial Services).
- The use of opportunities, like high-profile cases, to restate previous recommendations.
- Timely, eg, aligning with a current government agenda such as Vulnerable Children.
- Target environmental change so change is long-lasting and sustainable.

Traits of recommendations that fail to be implemented include the following:

- Vague. They might just say, 'X needs to happen' without a clear action to bring change:
  - 'Education should occur…'
- Principles and values that everyone would agree with, but continue to be vague, representing a vision rather than a practical action or recommendation.
- Good ideas, but may not be practical.
- Solutions without a clearly defined problem definition.
- No clear target agency or group that can or will work to implement them.
- Not a priority that attracts any funding.
- Poor timing, as in drowning recommendations in winter.
- Advocate for short-term behaviour change without environmental change.

Environmental change is critical for persistent, long-term success. Recommendations that advocate for behaviour change alone are weak.

It appears that targeting environmental change brings greater, persistent, long-term benefits than efforts solely targeted at behavioural change. For example:

- protecting children from fire is supported by flame-resistant nightwear
- to keep children away from slow-moving cars, build safe, fenced driveways
- rather than just promoting 'do not sleep babies in bed with you', provide families with safer protected sleep spaces for use in beds.

Good background work, consultation, pre-release of information, defining allies, identifying foes and preparing organisations to act can ensure recommendations fall onto fertile ground.

'We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too.' *John F Kennedy, September 1962*

Failure to implement is not always failure! Some recommendations need to be too hard to do easily now in order to set an agenda for transformational change in the future.