REPORT

Technical Resource Group

on

Developing a Sustainable model for LaQshya

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Key concepts and terms used in this document

Spread is 'when best practice is disseminated consistently and reliably across a whole system and involves the implementation of proven interventions in each applicable care setting'.

Sustainability is 'when new ways of working and improved outcomes become the norm.' In other words, it is when an improvement has become an integrated and the mainstream way of working. It should withstand challenge and variation over time, through a process of continuous improvement.

- Spread and sustainability are complex issues. This resource highlights a number of factors, both technical and social, which the literature suggests should be in place to successfully spread and sustain quality improvement.
- These interact in distinct ways depending on the context and level at which they are applied in the system, e.g. organisational or Macro level, group or Meso level, and individual or Micro level.

Psychology of Change is the science and art of human behaviour as it relates to transformation.

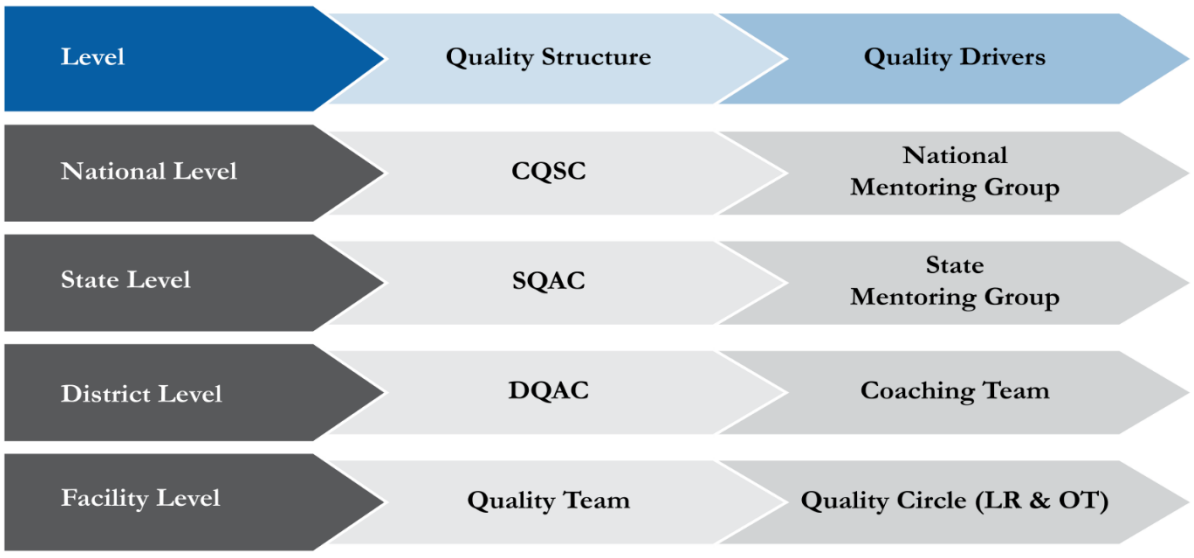
Background of LaQshya Programme

LAQSHYA is an initiative to improve the Quality of Care (QoC) in Labour Rooms (LRs), Operation Theatres (OTs) and other mother and child service areas in public health facilities across India. The program aims to reduce complications and deaths of mothers and babies around the period of child birth which contributes to highest proportion of maternal and newborn deaths. LaQshya brings together Quality Assurance (QA) and Quality Improvement (QI) approaches and strives to provide a better experience of care to the beneficiaries by integrating the concept of respectful maternity and newborn care.

Scope of Implementation

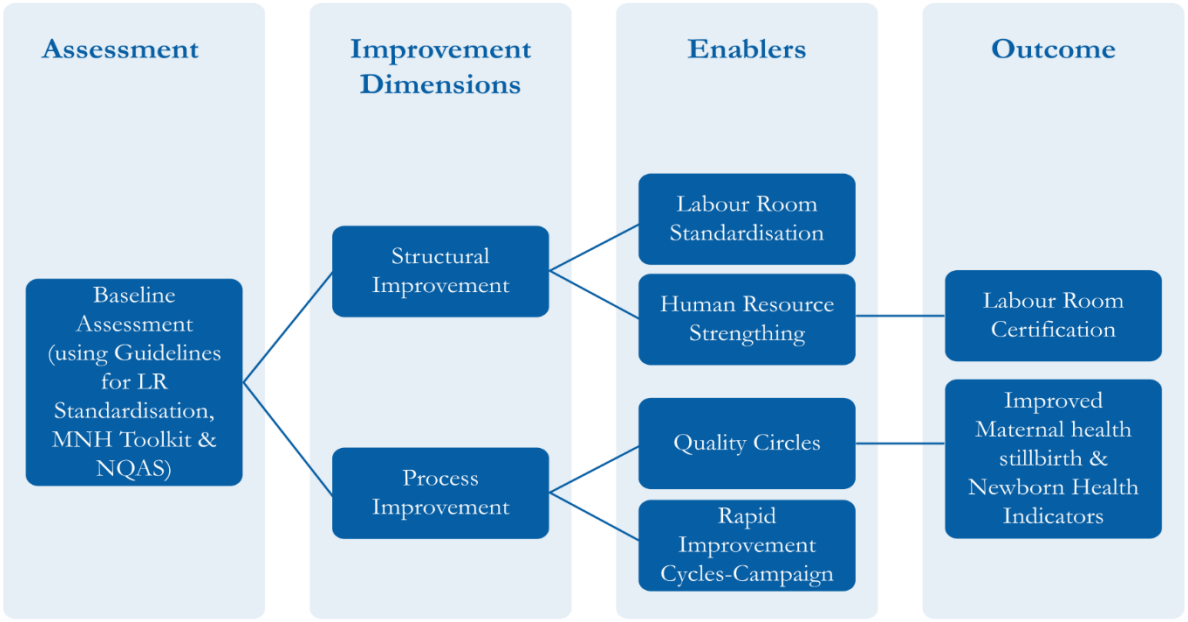
- This programme is implemented in Government Medical Colleges, District Hospitals, all First Referral Units (FRUs) and high caseload Community Health Centres (CHCs).
- Organization and Achievement of standards of LRs, OTs and Obstetric High Dependency Units (HDUs)/Intensive Care Units (ICUs) as per national guidelines and NQAS standards.
- Implementation of structured QI efforts, known as Rapid Improvement Cycles (RICs) to improve adherence to critical practices around childbirth affecting both, mother and baby.
- Provide maternal care to pregnant women (and newborn) with respect and dignity of the care recipient – known as Respectful Maternity Care (RMC).
- Improve satisfaction of the beneficiaries with the healthcare services provided.

Programme Structure



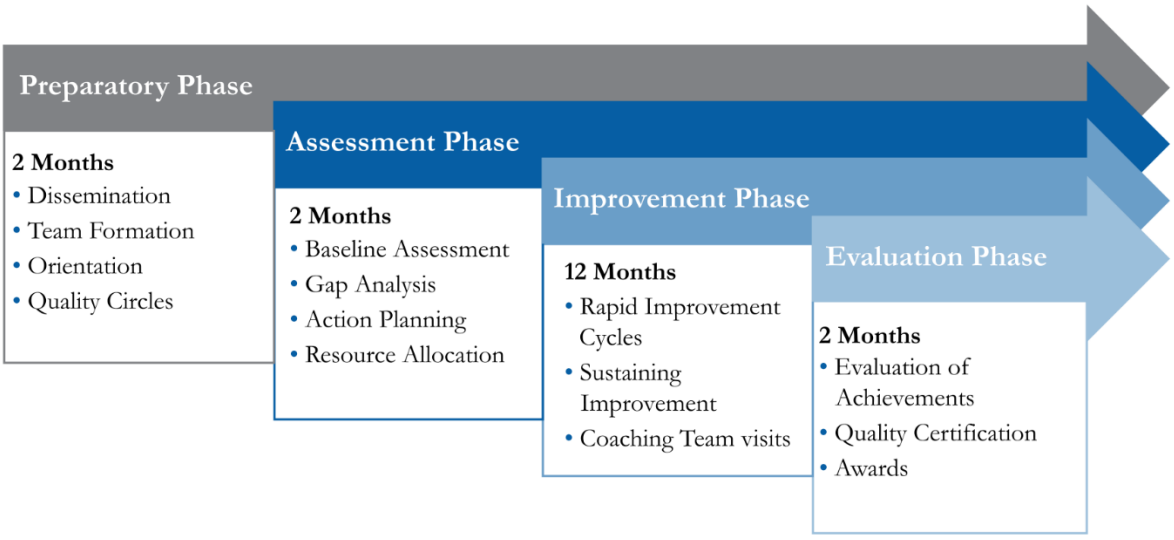
Source: LaQshya Guidelines. Maternal Health Division, MoHFW; 2017

Programme Framework



Source: LaQshya Guidelines. Maternal Health Division, MoHFW; 2017

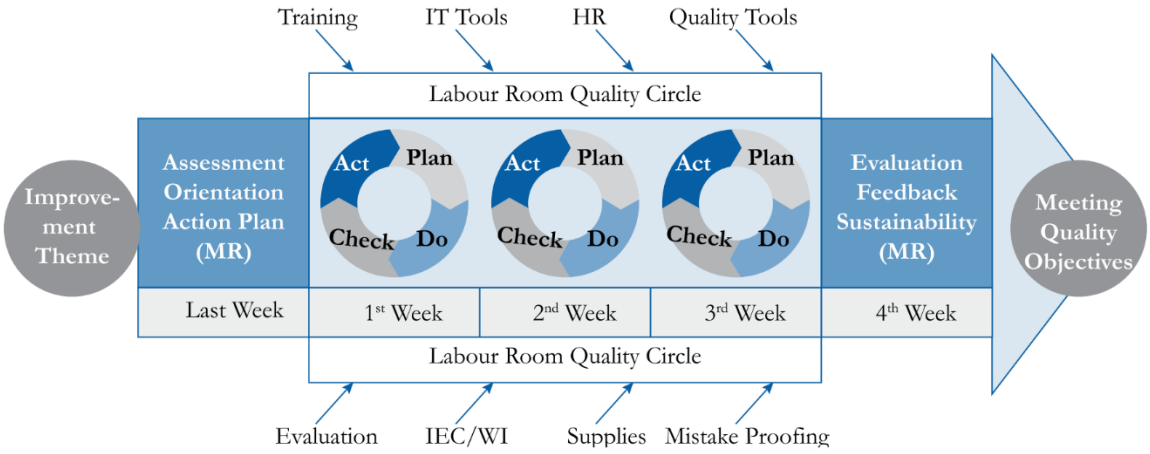
Activity Phases



Source: LaQshya Guidelines. Maternal Health Division, MoHFW; 2017

Pivotal Aspect of the Programme

The initiative prioritizes local problem solving utilising the PDSA (Plan-Do-Study-Act) approach to identify facility context-specific solutions; thereby ensuring ownership and accountability at facility level through formation of Quality Circles and Quality Teams. The common problems experienced by the facilities have been combined together into 6 QI cycles or RICs, with each having a defined set of 3-4 aims per cycles. Facilities have to complete each RIC over a period of 2 months (1-month of achieving improvement followed by 1 month of sustaining the gains achieved).



Source: LaQshya Guidelines. Maternal Health Division, MoHFW; 2017

Rapid Improvement Cycles (RICs)

a) Cycle 1: Real-time Partograph generation including shift to electronic partograph & usage of safe birth check-list & surgical safety check-list and strengthening documentation practices for generating robust data for driving improvement.
b) Cycle 2: Presence of Birth companion during delivery, respectful maternity care and enhancement of patients' satisfaction.
c) Cycle 3: Assessment, Triage and timely management of complications including strengthening of referral protocols.
d) Cycle 4: Management of Labour as per protocols including AMTSL & rational use of Oxytocin.
e) Cycle 5: Essential and emergency care of Newborn & Pre-term babies including management of birth asphyxia and timely initiation of breast feeding as well as KMC for preterm newborn.
f) Cycle 6: Infection Prevention including Biomedical Waste Management.

Certification and Branding

Quality Certification: The Labour Room & Maternity OT Checklists developed for NQAS, will be used as tools for the assessment and certification. The external assessment and certification will be done by external assessors empanelled with NHSRC. Certification will be valid for 3 years' subject to annual verification of the scores by the State Quality Assurance Committee.

Incentivisation: The teams in the Labour rooms and Maternity OT's at Medical Colleges, District Hospitals and SDH/CHCs could be given incentives of Rs. 6 Lakhs, 3 Lakhs and 2 Lakhs (for each department) respectively on achievement of following criteria:

a) Quality Certification of Labour Room and/or OT as per protocol under the NQAS.
b) Attainment of ≥75% of commensurate facility level targets and its verification by the SQAC.
c) 80% of the beneficiaries are either satisfied or highly satisfied.

Branding: The achievement of quality benchmarks should be used for branding of the QoC at the health facility. This will give sense of pride to the staff as well as provide confidence to the community

that they are getting quality care at public hospitals. There are three types of badges under this initiative:

a) Platinum Badge: > 90% Score.
b) Gold Badge: > 80% Score.
c) Silver Badge: > 70% Score.
d) These badges should be worn by the care providers as well as prominently displayed at relevant places in the hospitals.

Progress of LaQshya programme

Current status of the programme

Since its launch in December 2017, LaQshya programme has seen national certification being awarded to 319 LRs and Maternity OTs across the country. This number, however, is small when compared to the original intended target of getting 2,444 facilities Laqshya certified.

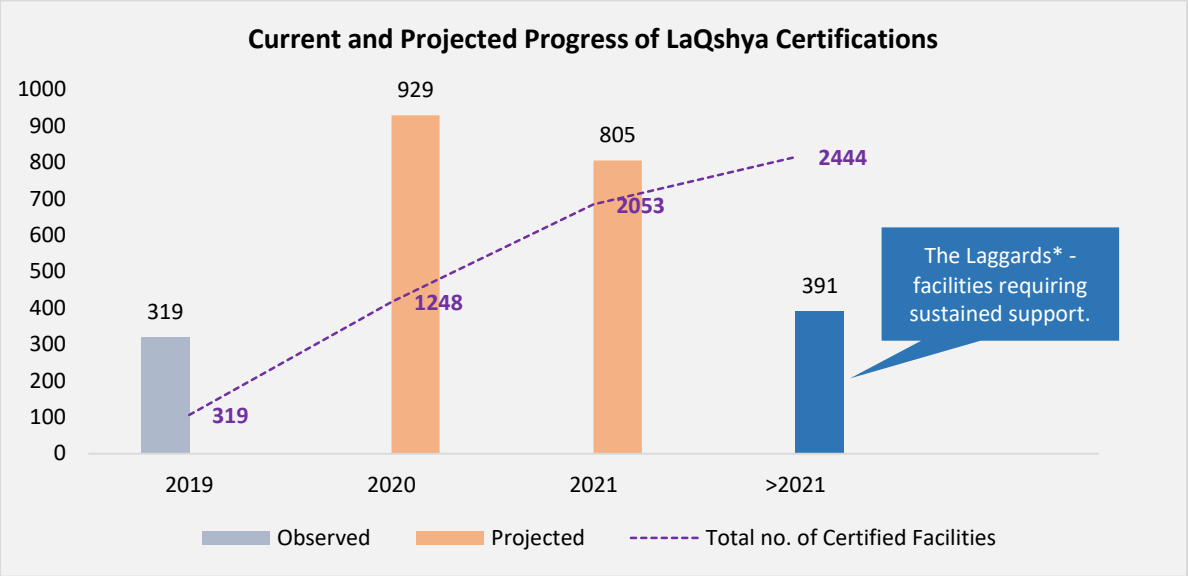


Figure 1: Current and projected progress of Laqshya certifications in 2019, 2020, 2021 and >2021. The violet line is the cumulative total of facilities that will be getting Laqshya certifications in coming years.
**The term 'Laggards' is used from EM Rogers Model of Diffusion of Innovation (1962; 2003).*
*** Data source: Laqshya PMU, updated till 08-Jan-20.*

Using the Diffusion of Innovation model, proposed by Everett M. Rogers – the adoption of Laqshya standards follows approximately the same trajectory, as can be seen from figures 1 and 2. This model highlights how a community adopts an innovation. This is a good model for understanding the uptake of Laqshya and its certifications since launch of the programme in Dec. 2017. Referring to Fig 1 and Fig 2, it can be stated that the certification process is currently fully saturated in the early adopters and will subsequently move over to saturate the early majority (i.e. state certified 929 facilities) in

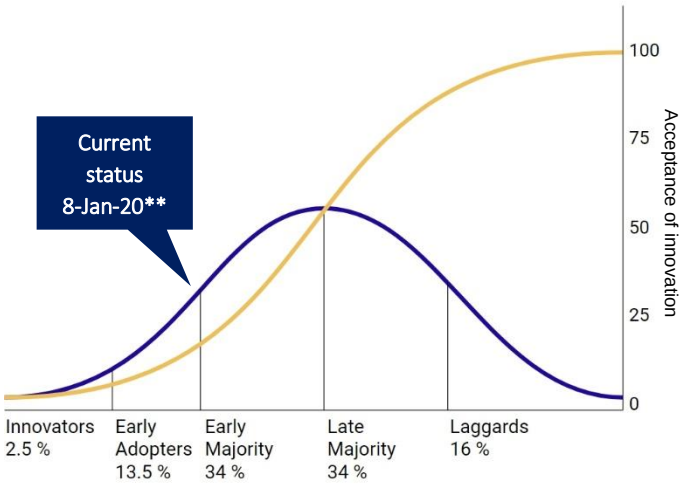


Figure 2: The diffusion of innovations according to EM Rogers. With successive groups of consumers adopting the new technology (shown in blue), its market share (yellow) will eventually reach the saturation level. The blue curve is broken into sections of adopters.

Adopted from: Rogers, Everett M. Diffusion of Innovations. New York: Free Press of Glencoe, 1962, 2003.

*** Data source: Laqshya PMU, updated till 08-Jan-20.*

2020.This is approximately 38% of the projected target and close to the Rogers model of Early Majority. Approximately 16% of the target facilities i.e. 391 will require extensive efforts to yield results and hence from a program point of view a special approach may be needed for their turn around towards certification.

Plan for taking Laqshya forward in 2020 and beyond

Utilising the above described model, the government should focus its energies towards getting the "early adopters and early majority" facilities to move towards national certification in 2020 i.e. the 929 state certified facilities.

For 2021, planning should be done in 2020 of getting the 805 of the remaining 1196 facilities, undergo national certification. This would leave 391 facilities to be taken up for national certification in years beyond 2021. These 391 facilities constitute the "Laggards" of the Diffusion on Innovations model. This term only reflects the "lag" and delay these facilities exhibit in adopting the innovations and is in no way reflection on functioning of these facilities. Due to the enhanced delays such facilities experience, it is imperative that these facilities be provided with longer/sustained handholding/ facilitation support for them to get to the national Laqshya certification.

Suggested Number of Facilities to Be Targeted for LaQshya Certification:

- 2020: 929 (Focus on State Certified Facilities)
- 2021: 805

Sustenance Plan for LaQshya

The success of a complex intervention depends heavily on its context, i.e. the underlying systems, organisational culture and the environment in which work is carried out during its implementation. Reproducing a complex intervention at scale is a much more distributed effort, often involving a good deal of creativity from those taking it up. In addition, sustaining an improvement requires a greater focus on adopters (and adapters), which requires implementing interventions in ways that support adopters to adapt them appropriately. A significant part of which is to create enabling environment that build adopters' commitment to implementing the intervention. Above all, a greater focus on adopters requires building their capability and readiness for implementation and providing them with the resources, time and space needed to do the hard work of translating the Laqshya guidelines to their own setting.

In this context, when we look at the Laqshya programme, its implementation across the country has moved forward, though issues and challenges do remain. The need of the hour is to address these challenges through sustainable solutions. The current document provides an overview of critical challenges across the program structure and suggests appropriate solutions to ensure sustainability and further streamlining of the program.

Bottlenecks in the current implementation of Laqshya programme:

Micro-level

- No documentation of what is going well in the facility which can be shared widely for learning.
- Hospital Leadership more concerned about getting the LaQshya Certificate but have not planned on how the facility will improve and continue to achieve better clinical outcomes.
- No review mechanisms in place for regular monitoring of clinical outcomes.
- Only few staff members interested and engaged in the QI process.
- Human resources constraints and frequent staff rotation within or across facilities.
- No incentives for staff who demonstrate creativity and share innovative change ideas for QI.
- Lack of coordination between heads of departments within facility (Obstetrics, Neonatology, Pathology etc.) and interfacility (CHCs and DH or DH and Medical College Hospitals).
- Majority of the facilities do not have defined processes and are not trained in using process mapping to identify areas of duplication, waste or inefficiency.
- A facility specific action plan is not developed to address the loop holes and hence no follow up is done.
- Lack of empowered cadre at facility level to make decision to improve care.
- Lack of a routine process to self-assess the facilities by the facility administration.
- Regular quality circle meetings are not held where these gaps can be discussed and a specific action plan can be made.
- No defined quality control mechanisms to ensure that the improvement achieved are being sustained.

Meso-level

- No committee dedicated for quality improvement.
- Weak facility level structure for QI and QA and no succession plans in place. The Hospital Quality manager is the responsible person for achieving QI in the facility. Being at a junior level he hardly has any authority to suggest major changes and his role is limited to getting certification.

- Majority of facilities are focussed towards getting certification. This is so, since there is a perception that certification equals quality, while certification is only a part of quality and does not equal quality.
- Lack of any direct involvement of community in co-production of healthcare services.
- Clinical competencies of the health care providers pertaining to MCH services remain low, which is linked to poor uptake of Dakshata trainings in states.
- Facilities lack a dedicated cadre for onsite mentoring for capacity building and hence Irregular mentoring of the staff nurses on the intrapartum and postpartum skills.
- Poor data capturing of health care data from data capturing and analysis.
- Lack of mechanism (Committee, funds, space, designing, layout, etc.) to improvise the existing infrastructure to ensure its compatibility with LaQshya norms.
- Non-involvement of Professional Organisations in the implementation of the LaQshya Program.
- Lack of integration of the Quality indicators in mainstream HMIS.
- Weak and deficient district and sub district health system.
- Issues related to availability of WASH services.
- Multiplicity of documentation with duplication of data.
- No defined quality control mechanisms to ensure that the improvement achieved are being sustained.

Macro-level

- State Mentoring Group (SMGs) and District Coaching Teams (DCTs) not operational.
- The programmatic preparatory phase and assessment phases were not completed prior to NMG visits.
- Traction for incentives not there (DH – 2) lakhs while Kayakalp provides incentive of 50 lakh). Laqshya has more elements to cover as well clinical outcomes-based tracking.
- Lack of ownership of the improvement initiative in state NHM's.
- Lack of coordination between Medical Education Department and State NHM's.
- Deficient community awareness and participation in the quality initiatives.
- Lack of a functional SQAC – which was to play a key role in operationalising the Laqshya programme and ensuring coordination with medical education department.
- Lack of clarity in financing mechanisms for basic resources and manpower at district facility level.
- Lack of clarity regarding recurring budget for operational MCH wings.
- Aspects related to Psychology of change missing from the implementation plan.
- Lack of clarity on the use of Technology for measurement and monitoring.
- Process ending at certification and incentivization of good work done by facility is not being done.
- Facilities slipping off after certification.
- Standardized client satisfaction processes not operationalized, Mera Aspatal not being utilized.
- No defined quality control mechanisms to ensure that the improvement achieved are being sustained.
- Identify a resource person for each area of Laqshya programme to help all the stakeholders from the health system to understand their roles and responsibilities, as shown in table below:

Table 1: Areas of Concern for Laqshya

	Area of Concern	Person Responsible
A	Service Provision	Civil Surgeon/ Facility In-charge, RMO & Matron
B	Patient Rights	Civil Surgeon & RMO
C	Inputs	RMO
D	Support Services	RMO & Matron
E	Clinical Services	Gynecologist, Medical Officer
F	Infection Control	Staff Nurses
G	Quality Management	Doctors/SN
H	Outcome	All of the above

Source: Dr Archana Mishra, DD-MH, Govt. of MP.

Sustainability or spread plan - for sustaining quality improvement efforts at micro, meso and macro level

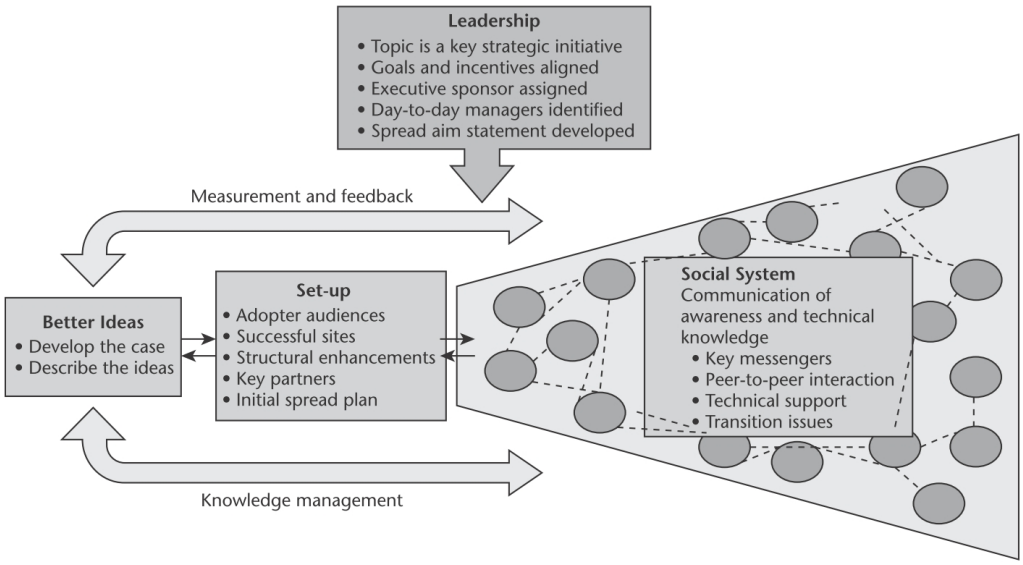


Figure 2: Framework for Spread.
Source: The Improvement Guide, 2nd edition. p196

As shown in the figure above, any framework for spread and sustenance requires an interplay of various factors viz. a strong leadership, identification of set of better ideas, availability of important inputs for development of spread plan, sound communication plan and most importantly, mechanisms for measurement, feedback and knowledge management. This plan thereafter requires, surgical precision in execution and further refinement - which consists of factors like identification of early adopters, capacity building teams, and taking steps to maintain the gains.

Quality Control and Quality Improvement (QC & QI)

A balance between QC & QI needs to be achieved for optimal functioning of any high-quality sustained health system.

Quality Control, focuses on monitoring the system, detecting emerging process problems and taking steps to address them. It is a continuous measurement strategy wherein processes are continually examined for conformance with aims/goals.

Quality Improvement, analyses the current processes, identifies the causes of poor quality, develops a set of change ideas to improve the process, tests these ideas and implements changes to redesign the processes. Following successful improvement, QC is used to monitor the redesigned processes to ensure it performs at the new level with new change ideas which have been previously tested using the QI approach.

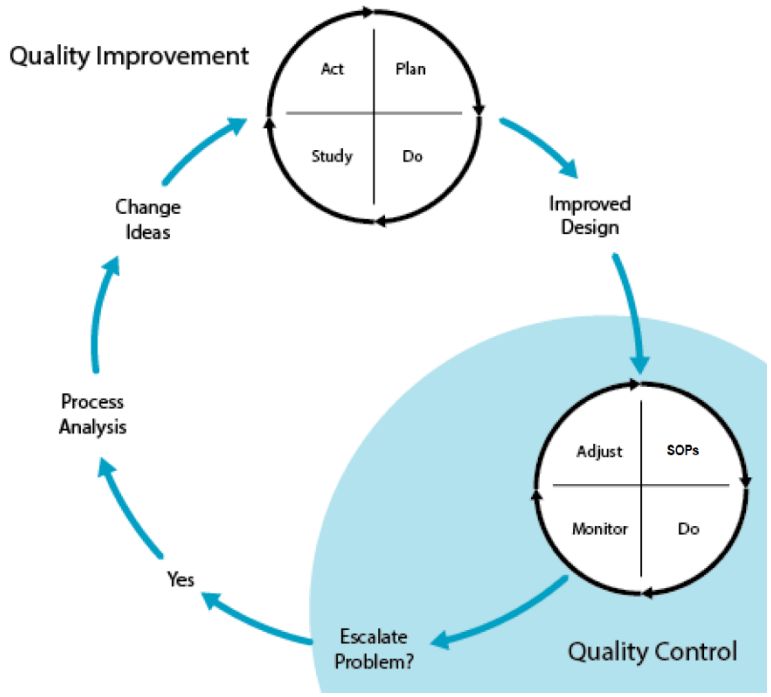


Figure 3: Interlinkages between quality improvement and quality control and how it is able to help solve the issues/challenges of a programme at beyond facility level.

Modified from: Scoville R, Little K, Rakover J, Luther K, Mate K. Sustaining Improvement. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

Psychology of Change

The psychology of change is the science and art of human behaviour as it relates to transformation. According to Dr. Deming (Improvement Thought Leader): "All improvement occurs in human system in which people interact with each other." He recommended, that for improvement to succeed leaders need to understand and master the broad area of psychology of change and interpersonal relationships. The IHI has proposed a framework for this – depicted in diagram below.

The basic objective of this framework is to create conditions that enable individual and groups to act with purpose in order to sustain improvement in healthcare. It is strongly suggested by TRG that the elements of psychology of change should be inbuilt across all levels of healthcare delivery system.

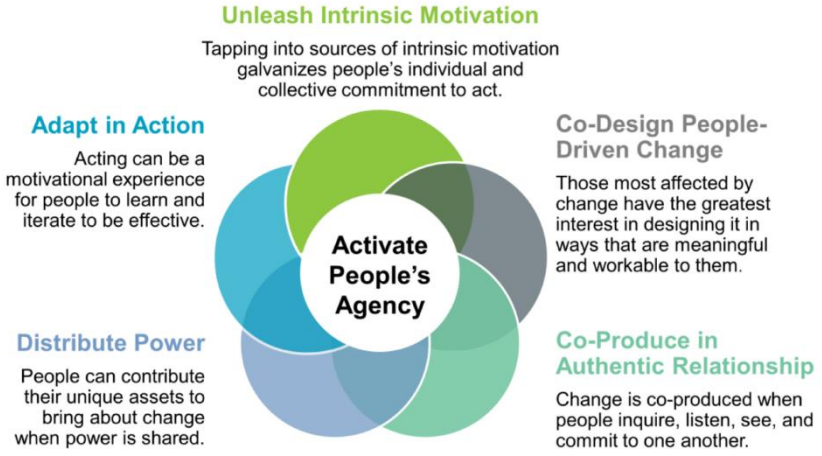


Figure 4: IHI's Psychology of Change Framework.

Source: Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

Figure 5: Areas of concern for sustaining Laqshya programme's gains.

Strengthening mentoring and creating local state capacity

Although as per Laqshya guidelines, it was the state medical colleges, that were supposed to undertake the mentoring of district level facilities with support from SQACs and DQACs. Though these bodies are functional in many states and have been driving the NQAS and Kayakalp programmes, they need to ensure engagement of State QA Units (SQAU) and their district equivalent DQAUs need to be improved. This is easier said than done, as these QA units have limitations esp. when it comes to offering clinical mentoring to the Laqshya facilities. This can be done by engaging medical colleges for mentoring the Laqshya facilities – this way the District Coaching Teams (DCTs) could also be operationalised as envisages in the Laqshya programme guidelines. These mentoring and coaching

visits can be used as a mechanism to develop capacities of SQAUs/DQAUs across the country to sustain the efforts of the facility level staff in implementing Laqshya guidelines in their facilities.

Role of nurses and nurse mentors

Nurses play a pivotal role in patient care and are often the care provider patients interact with the most during the course of their healthcare experience. Thus, they are one of the most important human resource for a health system to ensure better, quality health care services. Yet, nurses haven't been given the opportunity to be an active decision maker in the way a health system delivers care. With need for quality becoming an urgent need of the times, not only for the patients but also for the facility and for the health system at large – nurses have to play a pivotal role in deciding how care is delivered. This is more important for LMICs as they cater to the largest portion of population in the world.

In this context, role of nurses is of paramount importance – and equally important is the role of nurse mentors, who are the key pivot for developing capacities of their fellow nurses not only in clinical care but also in ensuring better understanding of health care data, its analysis and how to use it to solve patient care problems. These nurse mentors can be a part of the DCTs and/or work with these teams in tandem to ensure facility level staff is made capable to implementing and sustaining RICs. Moreover, these nurse mentors can be chosen from the same facility or surrounding facilities to ensure there is greater acceptance by fellow nurses posted in the DH/FRU-CHCs/CHCs/ block PHCs.

Role of SQAC & DQAC and their operationalisation

SQAC & DQAC were to play key roles in roll out and implementation of Laqshya programmes in the states/districts of the country. These bodies are responsible for ensuring there is adequate framework available with the states to successfully implement the Laqshya programmes' requirements and good coordination between the NHM, State Health department and Medical Education departments esp.to the programme needs. Currently, very few states have a good coordination between Medical Colleges and State NHM, leading to gaps in Medical College's understanding of the programme, its needs and how to implement those.

Creation of Measurement plan

Identification of dashboard quality indicators in sync with the 20 Laqshya indicators and incorporating them as a part of routine HMIS reporting.

National Resource Centre (NRC) & Regional Resource Centre (RRC) for QI as knowledge platform

Creation of NRC for QI to lead and synergise the efforts to implement Laqshya across India. in collaboration with a network of RRCs in EAG states to develop local capacity for conducting improvement work related to Laqshya RICs.

To create a system of collection, collation and analysis of data from states and facilitate cross learnings and experience sharing. The proposed structure of the NRC and RRC is shown in figure below:

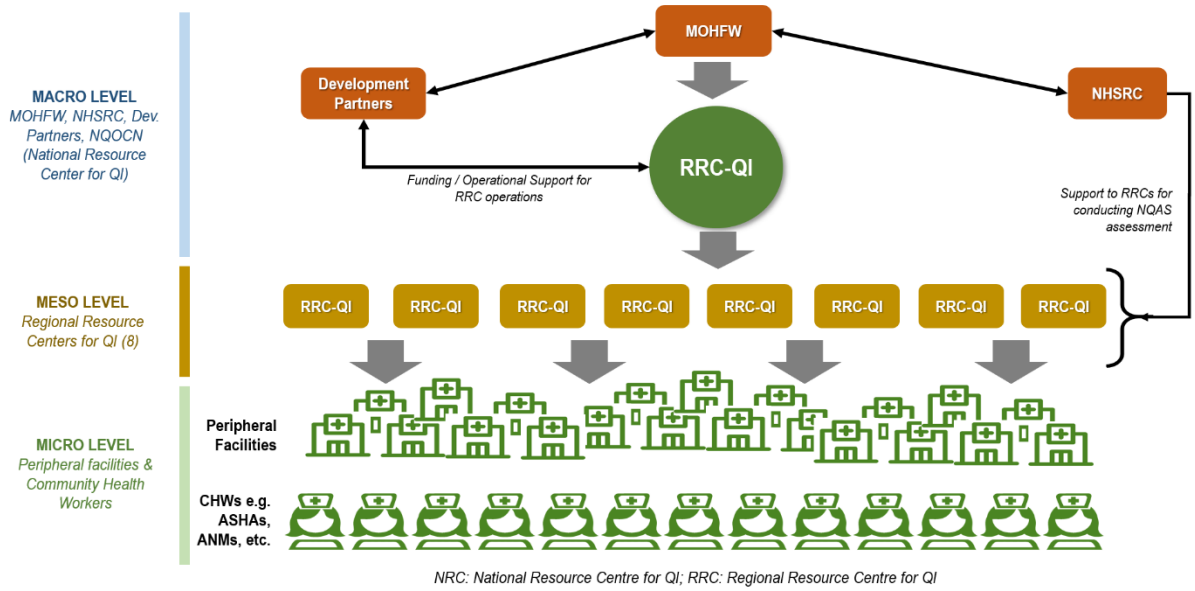


Figure 6: Schematic of National Resource Centre and Regional Resource Centres for QI to act as knowledge platforms for helping facilities and administrations in implementing QI processes.

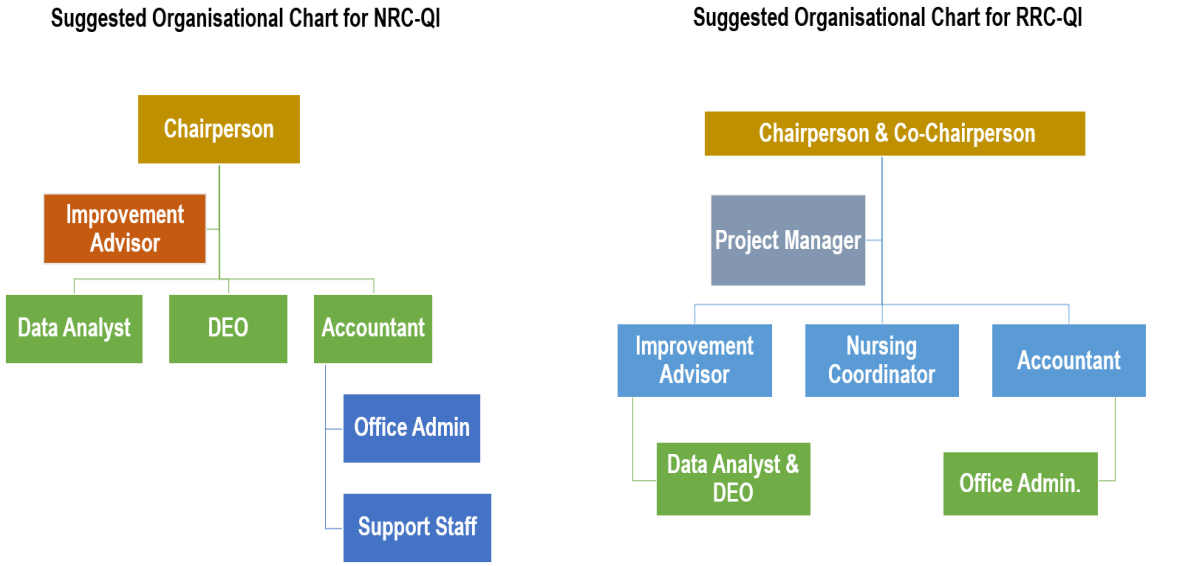


Figure 7: Organisational structure for NRC & RRC

OUTPUTS OF THESE CENTRES

- To create a cadre of hospital quality managers who will drive the improvement process at peripheral public health facilities across India.
- To develop capacity of identified/selected peripheral district and sub-district facilities in improvement skills to develop as sub-regional centres of excellence in providing quality health services across MNH's continuum of care model.

- To create a strong functioning network of national, regional, sub-regional and point of care facilities to bring about a shift in the quality of care framework towards a more patient centred, safe and equitable – responsive health system providing affordable care to the community.
- To accelerate the shift of existing health system towards a UHC centric approach where a delicate balance between QA and QI methodologies delivers highest level of health care to end users.
- To develop and demonstrate a replicable model of QI at grassroot health facilities in one district utilising ASHA facilitators and ANMs in health system strengthening with strong community participation.
- To provide technical support to facilities in closing gaps related to '*areas of concern*' - G & H standards of NQAS.

Innovations: Which can be scaled easily; are feasible and which need to be further strengthened -

1. List of successful actions taken which led to sustained improvements in LaQshya indicators

S. No.	Successful actions taken by teams-on-ground for sustained improvements
1.	E-partography
2.	Inclusive newborn care around child birth (preventing hypothermia, STS, EIBF and Inj. vit. K)
3.	Innovative technology which reduces the burden of the staff (e.g. promotion of E-partography, use of Apps, digitization of registers, state of art communication platform e.g. ECHO.)
4.	Using Brass V-drape to quantify the blood loss.
5.	Use of Birth companions
6.	Involvement of relatives for KMC or promote Family Participatory Care (FCC)
7.	Open-ended questionnaires for Patient feedback, which starts with – will you visit this facility again?
8.	Formation of micro-QI circle
9.	Involvement of NHM and development partners for commitment to improvement.
10.	Focus on initiating and frequent refreshments in competency base trainings of facility staff
11.	Regular meeting and motivation of nursing staff (e.g. via WhatsApp group and Zoom meetings)
12.	Onsite POCQI training workshops
13.	Counselling and use of Safe birth checklist
14.	Recognizing the local champions

2. List of measures that worked/will work to increase the community participation in driving LaQshya program

S. No.	Measures that worked/will work to increase the community participation in LaQshya program
1.	Family involvement for antenatal and postnatal counselling
2.	Involvement of ASHA workers and other frontline health workers (FLHWs).
3.	Patient feedback mechanism regarding the quality of services
4.	Feedback from community in the form of surveys
5.	Branding and promotion of LaQshya programme
6.	Maintaining the hygiene, sanitation and patient friendly environment in the hospital
7.	Use of 'Kishori Panchayats' to enhance community participation and will lead to creation of an empowered community.

3. List of suggestions for Facility level w.r.t Sustainability of LaQshya indicators

S. No.	Suggestions for facility level w.r.t. Sustainability of LaQshya Indicators	Short term (0-6m)	Medium term (0-12m)	Long term (0-24m)
1.	Formation and regular meetings of Quality circle and QI groups			
2.	Equal division of work and assignments within the members			
3.	Sharing of data and interpretation for self- assessment and self - improvement			
4.	Process indicators to be achieved in available resources.			
5.	In house Dakshata training and implementation			
6.	To avoid the rotation of LR and OT Staff			
7.	Identification and appreciation of performance-based reward system with names on the badges for recognition			
8.	Infrastructure upgradation as per GOI guidelines			
9.	Adequate availability of human resources and consumables			
10.	Data analysis of outcome indicators			
11.	Integration of POCQI in Nursing and medical cadre			
12.	Visual management: process performance information is continually available to synchronize			

	staff attention and guide current activities.			
13.	Assimilation: improvement projects are integrated into daily work.			
14.	Crises Resource Management (CRM)			
15.	Involve students from medical and nursing colleges to understand QI and become drivers of change/change leaders of future. (see figure 6 at the end of this table)			

4. **List of suggestions for State NHM level w.r.t Sustainability of LaQshya indicators**

S. No.	Suggestions for State NHM level w.r.t. Sustainability of LaQshya indicators	Short term (0-6m)	Medium term (0-12m)	Long term (0-24m)
1.	Uniform distribution of Budget according to the patient load			
2.	Initial gap analysis/ gap assessment/ preparatory phase			
3.	Mobilization of funds for upgradation of existing labour room, human resources and consumables			
4.	Availability of recurring funds			
5.	Periodic trainings or refresher trainings for upgrading LaQshya skills (Dakshata, Neonatal resuscitation, etc.)			
6.	Quarterly visits to facilities for monitoring the improvement of facilities.			
7.	Quarterly audits of LaQshya outcome indicators and gap analysis			
8.	Crises Resource Management (CRM)			

5. List of suggestions for MoHFW, GOI w.r.t Sustainability of LaQshya indicators

S. No.	Suggestions for MoHFW, GOI w.r.t. Sustainability of LaQshya indicators	Short term (0-6m)	Medium term (0-12m)	Long term (0-24m)
1.	Intersectoral coordination of health and education system at national, state and local level			
2.	Appreciation and incentive awards			
3.	Monitoring of LaQshya Outcome indicators			
4.	Continuous allocation of funds			
5.	Final accountability for achievement of LaQshya			
6.	App development for easy flow of data			
7.	MCH wings: their construction and upgradation (where required) at all identified facilities as per MNH toolkit. Along with provision of recurring budgetary allocations.			
8.	Crises Resource Management (CRM)			

Figure 8: 'Be The Change' model of pre-service QI training to ensure better uptake and sustenance of improvement.

Recommendations for Spread and Sustainability

Taking a note of the complex array of bottlenecks associated with the Laqshya programme and the need for a quality control mechanism as shown in driver diagram below. The TRG proposes the following recommendations which may aide the spread and sustainability of the Laqshya programme in 2020 and beyond.

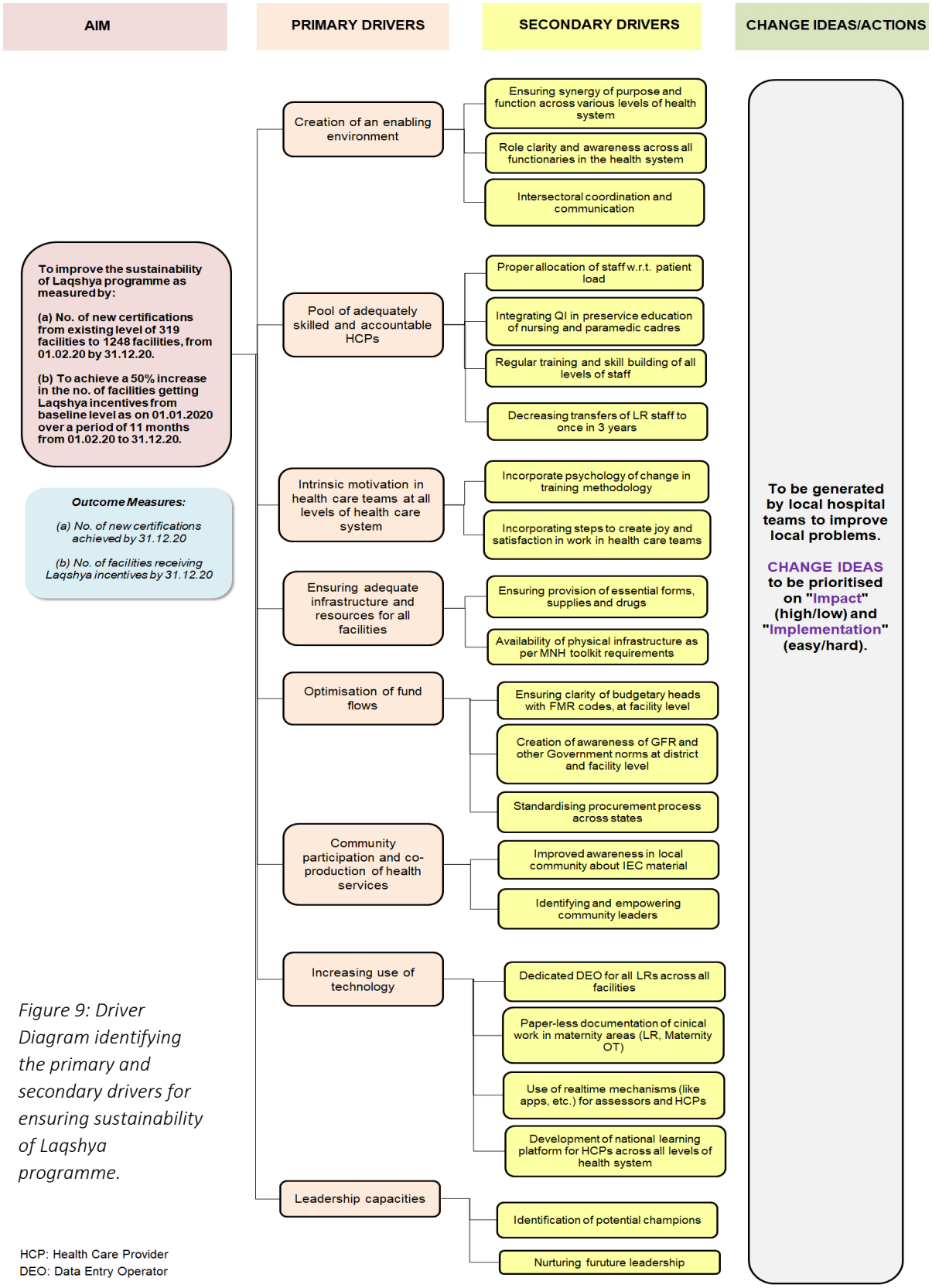


Figure 9: Driver Diagram identifying the primary and secondary drivers for ensuring sustainability of Laqshya programme.

HCP: Health Care Provider
DEO: Data Entry Operator

Micro Level (Facility Level):

- As described in the LaQshya guidelines every facility needs to form Quality teams for labour room, OT, SNCU, wards etc. A clinician needs to be a member of every team to ensure that the projects focus on clinical outcomes.
- The facility needs to develop a driver diagram for the facility for a period of 1-2 years. Different teams need to develop driver diagrams for identified projects which could be for periods varying from 3 to 6 months. (Reducing antibiotic use; increase adherence to partograph use; early initiation of BF; etc.)
- The Facility leadership needs to convene monthly meetings of the Quality teams and keep record of the proceedings, prepare action taken reports etc.
- The Facility Leadership needs to ensure that all staff members are trained on QI (LaQshya) and are motivated to participate in QI projects. A culture of involvement needs to be created so that staff members feel empowered to come up with innovative change ideas.
- The Quality Team leaders need to address concerns of staff members, including clinical and non-clinical staff. Use various tools to ensure maximum involvement of staff in decision making.
- Policy on HRH in LR and SNCU, regarding non-rotation, equal availability across shifts and presence of buffer staff to tackle sudden exigencies.
- Incentives, not necessarily financial, for staff who demonstrate creativity in implementation of QI.
- Inter-departmental coordination meeting HODs and quality teams.

Meso Level (District Level):

- The district leadership (DMHO, Civil Surgeon) need to have a comprehensive Quality Assurance and Quality Improvement Governance Structure in place which includes all audits (Death audits, prescription audits, referral audits, drug audits, etc.) along with certifications (NQAS, LaQshya etc.)
- Given that clinical and mortality outcomes at the district level will depend on the overall performance of all facilities as well as community-based services, the district Quality Team under the leadership of the District Medical and Health Officer and Civil Surgeon needs to take a holistic view of Quality Improvement. There is a need to institutionalise a cluster approach to track Quality Improvements at the district level given that there are strong referral linkages between primary, secondary and tertiary care facilities in the district.
- The District team needs to keep a tab on balancing indicators such as referrals, LAMA (Left against Medical Advice) of each facility to ensure that the gains shown by individual facilities are true gains and not because of referring out critical patients or showing them as LAMA.
- Identify a list of mentors (Medical College teachers, professional bodies – FOGSI, NNF, IAP, development partners and technical organizations) and map them to facilities. Prepare a half yearly mentoring calendar for the district.
- Develop a system to collect change ideas and QI projects across facilities in the districts under LaQshya and promote cross learning through learning sessions using Skype / Zoom etc.
- Developing a ranking system for facilities based on the "**engagement score**" (see Annexure) as well as number of QI projects being implemented across facilities to build a culture of competitiveness amongst facilities. Develop a system to declare a District Quality champion for the month and the Facility with Best Clinical Outcomes for the month.
- Organize a monthly **cluster meeting**[#] (see Annexure), either in person or through teleconference, including the Quality team leaders from the cluster. The meeting will include

discussion around management of referred critical cases, Maternal Near Miss, Maternal Death, Perinatal Deaths and update regarding the ongoing QI projects.

- Policy on HRH in LR and SNCU, regarding non-rotation, equal availability across shifts and presence of buffer staff to tackle sudden exigencies.
- Allocation of specific mentors from state NHM/DQAC to handhold allotted facilities.
- Fixing of data and time for regular quality circle meetings, to be chaired by the administrative head of the facility.
- Quality Cadre: Develop a dedicated cadre for quality professionals across all DH, CHCs – who can be deployed following example of SNCU deployment of staff for at least 3 years in one posting. This is very important, as learned from the Laqshya experience and experiences of other speakers, lot of facilities will take time to come around to ways of quality of care being an essential and everyday part of care.

Macro Level (State and National Level):

- RICs of fixed duration have clearly not been possible. Possibly, it is time to revise strategy for implementation of RICs.
- LaQshya materials need contextualisation when used in facilities other than medical colleges.
- Clear communication from top for local buy-in. Mentors shouldn't have to explain who they are and why they've come.
- Role clarity needs to established for all stakeholders: clinical mentoring vs. mentoring for LaQshya certification vs. mentoring for carrying out RICs.
- Active role by SQAU/DQAU in managing Laqshya mentoring (of all the 3 types noted above).
- Planning and carrying out visits be made easier for mentors.
- Strengthening of midwifery programmes with QI methodology and incorporation of pre-service QI in existing curriculum.
- Formalise the Technical Resource / Working Group for Quality Improvement at the national level including the relevant development partners.
- Identify and notify regional Resource Centres / Centres of Excellence for Quality Improvement in India with a clear organogram and Governance structure and funding to support the linked states in driving and consolidating Quality Improvement efforts in MNCH. These could be Medical College Hospitals one each in North, Centre, South, East, West and North East India.
- Active engagement of Child Health Division, MOHFW and RRCs for FBNC in the implementation and sustainability of improvements achieved.
- Organize National level, half yearly one / two-day review meeting / Learning session in each region in the Centre of Excellence where the identified district champions and the facilities with best clinical outcomes are given an opportunity to present their QI work in front of all district nodal officers from the region and are felicitated.
- Policy on HRH in LR and SNCU, regarding non-rotation, equal availability across shifts and presence of buffer staff to tackle sudden exigencies.
- Arrangements for sustenance of programme management unit like structure at MOHFW for next 5 years, at least to oversee coordination and conduction of various activities under Laqshya programme.
- An important part of sustenance will be development of assessment conduction capacity of the National NHM (NHSRC) / State NHMs to be able to handle all the assessment load. In order to develop capacity for assessment, it would be good to rope in community medicine departments of medical colleges to help in conducting these assessments for the programme.
- The best projects identified from these meetings can be presented in the annual good practices and innovations summit on a separate day which should be dedicated for Quality Improvement.

- A dynamic dashboard needs to be developed at the national level which will display the engagement scores of facilities across the country as well as regional / state / district and facility level rankings. The dashboard should also be able to display the ongoing QI projects which can be categorised based on thematic areas (Cycles), location, speciality etc. There should be real-time reporting of LaQshya assessment as well as the scores achieved. It should also include a mentor management portal which will show the status of mentoring visits across the country. This will also help the ministry / the partners to schedule the mentoring across the country. All mentors should be enlisted on this portal and we could develop a system of providing star rating to mentors based on the feedback from facilities.
- Quality Cadre: Develop a dedicated cadre for quality professionals across all DH, CHCs – who can be deployed following example of SNCU deployment of staff for at least 3 years in one posting. This is very important, as learned from the Laqshya experience and experiences of other speakers, lot of facilities will take time to come around to ways of quality of care being an essential and everyday part of care.
- Private Sector Engagement: Develop mechanisms to involve private sector in a sustainable way in the quality paradigm. This is of utmost importance since pvt. sector is responsible for biggest chunk of OPD care and a sizeable part of IPD care. PMJAY-AB, maybe, can lead the way in helping develop a model of Quality of Care delivery that will rope in more pvt. sector facilities esp. the small and medium bed strength hospitals. The same hospitals that cater to largest chunk of population and are missed by lot of QA mechanisms due to paucity of funds.

Increasing Community Participation

- Increase community awareness and participation using IEC material in local language.
- Ensuring partnership between community and health care facility using local leaders /Panchayati raj functionaries and volunteers.
- Involve Adolescent girls as empowered “Sakhi’s” of antenatal mothers to counsel and ensure their wellbeing.
- Increasing community awareness and utilisation to Laqshya entitlements through appropriate media (Radio, TV, Print)
- Development of “patient feedback forms” to be filled and submitted at the time of discharge.
- Establishing systems for grievance redressal at facility.
- Mobilising communities and to form a nodal agency at village level which is responsible for decentralised health care linkage by Women self-help groups and Village coordination committees.
- Community Medicine Department of regional medical colleges can help in developing effective and acceptable BCC strategies.
- Strengthening of Rogi Kalyan Samities.
- Online Linkage of facility level grievances with state functionaries at state headquarters.
- Empowering community to actively participate in the functioning and quality improvement of the health facility as a partner.

For Medical Colleges

- Medical colleges should complete the basic set pf activities (self-assessment scoring etc.) before mentoring is to happen. Mentoring on rapid improvement cycles is possible only if basic structural issues are sorted.

- Selection of which medical colleges to be mentored must figure in whether the local managers/clinical leads are interested.
- Engagement of medical education cell/DMRE of the state and state NHM on the same platform to understand the gaps in Laqshya certification and how to close them.
- Introducing culture of quality and openness towards change by understanding improvement methodology, e.g. have a 6-monthly workshop in Deptt. of Obstetrics and Gynaecology (ObsGyn) to this effect.
- Making the HOD ObsGyn the Laqshya nodal of medical college to implement all aspects of the Laqshya programme.
- Orientation to concepts of content and experience of care building a culture of respectful maternity care.
- Orientation to standard treatment protocols along with skill training in Obstetrics and Newborn care for capacity building of healthcare staff. This should be done at preferably at 6-monthly intervals.
- Integration of principles of quality improvement into the undergraduate and postgraduate medical curriculum (can be done by means of yearly workshops).

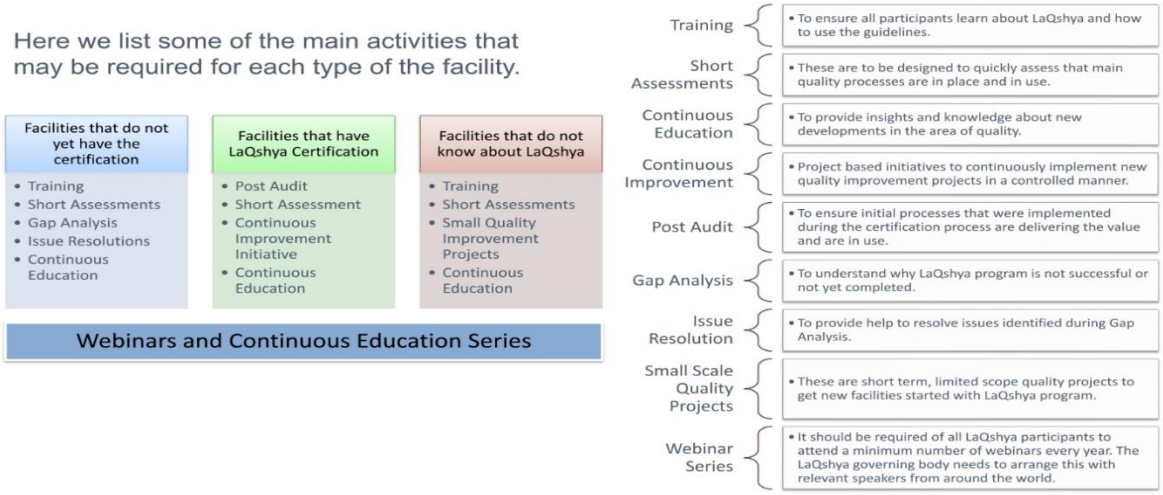


Figure 10: Stratified sustainability plan for Laqshya implementation in various facilities

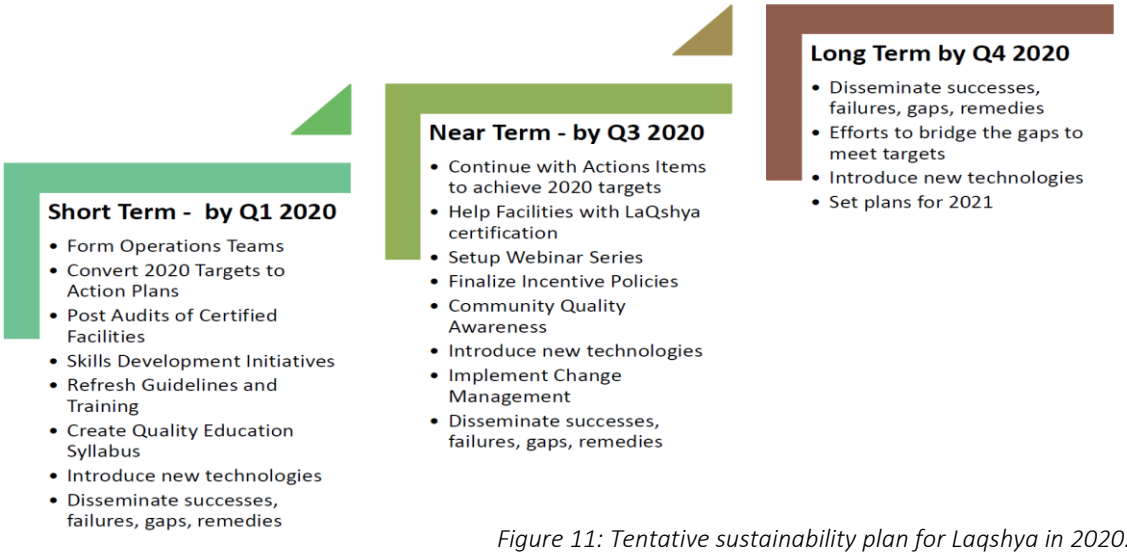


Figure 11: Tentative sustainability plan for Laqshya in 2020.

Annexure:

*Engagement Score is a method devised by the Institute for Healthcare Improvement to uniformly grade the level of responsiveness of the health facilities to the quality improvement intervention. There are ten levels of engagement and each level is scored 0.5 so the maximum engagement score would be 5.

The Engagement Score:

Score	Definition	Operational Definition of Engagement Score
0.5	Intent to Participate	Project has been identified, but the charter has not been completed nor team formed.
1.0	Charter and team established	A charter has been completed and reviewed. Individuals or teams have been assigned, but no work has been accomplished.
1.5	Planning for the project has begun	Project structure established, and work has begun (such as: identified required resources, set priorities for how to start the work, meeting schedule developed).
2.0	Activity, but no changes	Initial cycles for team learning have begun (project planning, measurement, data collection, obtaining baseline data, study of processes, surveys, etc.).
2.5	Changes tested, but no improvement	Initial cycles for testing changes have begun. Most project goals have a measure established to track progress. Measures are graphically displayed with targets included.
3.0	Modest improvement	Successful tests of changes have been completed for some components of the change package related to the team's charter. Some small-scale implementation has been done. Anecdotal evidence of improvement exists. Expected results are twenty percent complete.
3.5	Improvement	Testing and implementation continues and additional improvement in project measures towards goals is seen.
4.0	Significant improvement	Expected results achieved for major subsystems. Implementation (training, communication, etc.) has begun for the project. Project goals are fifty percent or more complete.
4.5	Sustainable improvement	Data on key measures begin to indicate sustainability of impact of changes implemented in system.
5.0	Outstanding sustainable results	Implementation cycles have been completed and all project goals and expected results have been accomplished. Organizational changes have been made to accommodate improvements and to make the project changes permanent.

- *Note 1: This may mean either that a) twenty percent of project numeric goals have been met or b) each measure is showing 20% improvement towards goal.*
- *Note 2: This may mean either that a) fifty percent of your numeric goals have been met or b) each measure is showing fifty percent improvement towards target.*

 # Cluster: it includes a group of health facilities which includes a tertiary care hospital (Hub) and district / sub district / lower facilities (Spokes) which are geographically linked to the tertiary hospital and usually refer patients for advanced care. Clinical outcomes in the hub facility are influenced by the condition / criticality of the patients referred to it from the spoke facilities, hence for overall improvement in clinical outcomes in the district it is important that all facilities in the cluster take joint responsibility and collaborate in driving Quality Improvement initiatives.