How we can spread Improvement: A Wessex exemplar

Dr Kate Pryde
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A Framework

Innovation → Spread → Adoption → Implementation → Sustainability

Healthcare Improvement Scotland, 2013
## Innovation Attributes

<table>
<thead>
<tr>
<th>Standard</th>
<th>Operational</th>
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</thead>
<tbody>
<tr>
<td>Relative advantage</td>
<td>Task Relevance</td>
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<tr>
<td>Compatability</td>
<td>Task performance</td>
</tr>
<tr>
<td>Complexity</td>
<td>Feasibility</td>
</tr>
<tr>
<td>Triability</td>
<td>Implementation Complexity</td>
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<tr>
<td>Observability</td>
<td>Divisibility</td>
</tr>
<tr>
<td>Re-invention</td>
<td>Nature of Knowledge required to use it</td>
</tr>
</tbody>
</table>

Greenhalgh et al. *How to Spread Good Ideas*, 2005
Sequence for Improvement

1. Theory & prediction
2. Develop a change
3. Test a change
4. Test under a variety of conditions
5. Implement a change
6. Make part of routine operations
7. Sustain & spread a change to other locations

Support with data and consideration of people

Based on slide © IHI 2009
If you want to go fast, go alone.

If you want to go far, go together.

-african proverb
Diffusion & Dissemination
Pressures accelerating Innovation

- **Top down**: 
  - Central requirement
  - Regulation and incentives
  - Support, skills development

- **Horizontal**: 
  - Peer influence
  - Transparent reporting
  - Collaboration & competition

- **Bottom up**: 
  - Patient and public demand
  - Front line worker enthusiasm
  - Entrepreneurialism
Communication Strategy
AT LEAST WE FOUND A USE FOR THOSE!
Adopting Innovation

Everett Rogers defines diffusion as the process by which an innovation is communicated through certain channels over time among the members of a social system.
Create a plan before, during and after implementation of your improvement initiative.
Is the project work you undertook as part of fellowship still in place?

1. Patient Benefit
2. Clear evidence of value
3. Stakeholder engagement
4. Attitude (culture) change
5. Network support
6. Continuous improvement
Feedback from QI fellow survey - Spread

Has the project work you undertook as part of fellowship spread?

1. Clear patient benefit
2. Local diffusion
3. National bodies adopted
4. Education programmes
5. Standardization of processes reducing variation
Trauma Improvements

Trauma is the leading cause of death in children >1 year

Trauma outcomes in UK significantly poorer than comparable developed countries with 20% increased mortality rate

Wessex Major Trauma Network
Trauma Interventions

QI Fellow
MTC Trauma Lead
Wessex Trauma Network
PIC Forum

Team Structure
Trauma Handbook
Trauma Documentation
Education programme

Team Based
Simulation programme
Now major trauma centre:

Time to intubation = 10 mins
(vs 57 in 2010)

Time to CT = 20 mins
(vs 102 2010)
**Context**

Rising prevalence of people with dementia

43,000 people in Wessex with dementia with ~25,000 of these on dementia registers

People living with dementia are expected to double within the next 20 years

Variation in diagnosis rates

get to achieve 67%

diagnosis rates between CCGs from 59% - 67%

**The Programme**

An innovative quality improvement programme to better manage the pathway of patients with dementia and their carers through primary care

**CONTROL**

- Assessment and early identification of Dementia
- Patient-centred care plans

**EDUCATE**

- Dementia Champion
- Skilled staff who has time to care

**DESIGN**

- Creation of a dementia-friendly environment
- Lighting, wayfinding

**PARTNERSHIP**

Working with and support of
- patients,
- carers,
- families and friends
Improving dementia care

Adoption and Spread

Our approach
- Local innovator
- Clinical champion and early adopters
- Context enabled by national policy
- Influential voluntary sector voice
- Positive early evaluation
- Combined diffusion and dissemination approaches

- 116 Wessex practices engaged in the programme
- 24 have completed

Spread and adoption already to other geographies

Target coverage of 75% of Wessex GP surgeries by 2018

Results so far

Staff: “We can’t imagine being without [iSPACE] now”

GP: “It provides structure and reproducibility in making primary care practices dementia friendly”

Carer: “he feels more confident now and that has helped improve things”

- Increase in number of persons diagnosed with dementia
- Increase in number of patients on dementia registers
Improving Situational awareness to improve Patient Safety: Implementing SAFE Huddles
S.A.F.E. Huddles are coming soon to PMU.

The aim of a SAFE huddle is a brief exchange of information within the team, ensuring that concerns, ‘gut-feelings’, parental anxiety & deteriorating clinical parameters are escalated promptly to ensure improved outcomes for patients. It is also an opportunity for communicating important information.

To begin with huddles will happen once a day but we aim to increase to 2-3 times each day with all members of the team.

A huddle is a short (10 mins max) information exchange following a structured format, managed by the nurse/clinician in charge, using an established framework.

The aim is to improve patient outcomes by providing early intervention, rapid debrief and identification of learning from good practice and adverse incidents. Facilitating development of a proactive safety culture.

**How will it help me & my patients?**

**How does it work?**

**What’s a huddle?**

**When does it happen?**
FERF the concept...

Slide courtesy of Clarissa Chase
FERF the process...

Slide courtesy of Clarissa Chase
FERF the evolution...
Practical Tips for Successful Sharing – 7 Spreadly Sins

**SIN:** Expect huge improvements quickly then start spreading right away.
**DO THIS INSTEAD:** Create a reliable process before you start to spread.

**SIN:** Don’t bother testing—just do a large pilot.
**DO THIS INSTEAD:** Start with small, local tests and several PDSA cycles.

**SIN:** Spread the success unchanged. Don’t waste time “adapting” because, after all, it worked so well the first time.
**DO THIS INSTEAD:** Allow some customization, as long as it is controlled and elements that are core to the improvements are clear.

**SIN:** Check huge mountains of data just once every quarter.
**DO THIS INSTEAD:** Check small samples daily or frequently so you can decide how to adapt spread practices.

**SIN:** Require the person and team who drove the initial improvements to be responsible for spread throughout a hospital or facility.
**DO THIS INSTEAD:** Choose a spread team strategically and include the scope of the spread as part of your decision.

**SIN:** Give one person the responsibility to do it all. Depend on “local heroes.”
**DO THIS INSTEAD:** Make spread a team effort.

**SIN:** Rely solely on vigilance and hard work.
**DO THIS INSTEAD:** Sustain gains with an infrastructure to support them.

**SIN:** Check huge mountains of data just once every quarter.
**DO THIS INSTEAD:** Check small samples daily or frequently so you can decide how to adapt spread practices.

SOURCE: Institute for Healthcare Improvement. Used with permission.
Thank you

Kate.Pryde@uhs.nhs.uk
@katepryde