Developing a model for spread and adoption of innovation in healthcare
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National Patient Safety Collaborative Learning Event

23 May 2017
Workshop objectives

• To explore the **structures and resources** needed for large-scale spread and adoption of innovation in healthcare, working across geographic, organisation and team boundaries.

• To understand the **leadership capability and behaviours** required for large-scale spread and adoption of innovation and improvement in healthcare.

• To understand the processes involved in **a collaborative model for improvement** - we will share our learning from this approach.

• To understand the significance of **leadership development and measurement for improvement** for supporting spread and adoption of innovation.
Introductions

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Introductions within groups

You will be working together in groups.

Take a few minutes to introduce yourselves to each other at your tables.
Definitions

Innovation
‘an idea, service or product, new…to the NHS, which significantly improves the quality of health and care…’ (Department of Health, 2011, p. 9).

Adoption
‘putting’ the innovation ‘into practice’ (Department of Health, 2011, p. 9).

Spread
‘the systematic uptake’ of the innovation ‘into widespread use across the whole service’ (Department of Health, 2011, p. 9).
Paradigms of diffusion and dissemination: underlying concepts, theories and metaphors on the nature of spread

Source: Greenhalgh et al., 2004, p. 119
You want others to benefit from your innovation, both within your region and across the UK.

**Spreaders:**
How might you spread your innovation to other regions and support adoption?

**Adopters:**
What might you need to help you adopt this innovation?

**Exercise:**
At your tables, think about the sections on your worksheet, discuss amongst yourselves and complete the sheet.

10 mins, followed by 10 mins feedback.
Feedback: Spenders

**Data** – what do you need to support a case for change?

**Communication** – who do you need to convince?

**Scale** – where are you spreading to and how will you chose adopters?

**Team members** – who and what roles will you need to support the spread effort? Consider if these people might be outside your own team or organisation.

**Leadership** – what leadership capabilities and behaviours will your team need to demonstrate to enable spread and adoption?

**Evaluation** – how might you measure success?

**Sustainability** – how will you ensure change is embedded and sustained?
Feedback: Adopters

**Data** – what do you need to support a case for change?

**Communication** – who do you need to convince?

**Team members** – who and what roles do you need to support the adoption effort? Consider if these people might be outside your own team or organisation.

**Leadership** – what leadership capabilities and behaviours will your team members need to demonstrate to enable adoption?

**Evaluation** – how might you measure success?

**Sustainability** – how will you ensure change is embedded and sustained?
Things to consider

**Rationale and case for change** – evidenced understanding of the problem being addressed, a clear explanation of the intervention and evidence of effectiveness.

**Communication plan** – understanding the context in which you will be implementing the innovation, who needs to be involved, why they need to be involved and the information they require.

**Recruiting the teams** – both for spread and for adoption. Core team to spread the innovation and to encourage adoption and local teams to support adoption. Likely to include: clinical champions, project managers, facilitators, advisors, and analysts. **Think about skills, experience and leadership behaviours.**

**Delivery plan** – describing how the team members will work together, when and how will the innovation be implemented, how you will sustain behaviour change, how you will overcome barriers to implementation. **Think about skills, experience and leadership behaviours.**

**Measurement plan** – what you will measure, how you will measure it, how you will help adopters to measure improvements and to demonstrate they have made a difference.
Our operating model for spread and adoption of a care bundle

Cross-AHSN Programme Team: Responsible for spread and adoption across all regions - A group consisting of regional AHSN team members, clinical lead (originator of care bundle), programme manager, data analyst and QI advisors.
- Makes decisions and agrees actions informed by collective feedback.
- Provides overarching collaborative leadership, clinical leadership, programme management and support.
- Develops and maintains relationships with all adopters.
- Provides tools and training to all adopters.
- Organises cross-AHSN opportunities for collaboration.
- Tracks performance across the programme and reports progress.

AHSN1 leads

AHSN2 leads

AHSN3 leads

Hospital teams

Adopters (hospital teams): Multi-professional teams that include clinicians and quality improvement managers.
- Put change management and QI learning into practice.
- Attend collaborative events and share progress, issues, barriers, successes, and learning.
- Responsible for leading local adoption of care bundle within own organisation and improvement of clinical performance.

AHSN leads: Responsible for spread and adoption within own region - A group consisting of local AHSN team members, i.e. clinical leads and a project manager.
- Makes decisions and takes actions informed by collective and local feedback from adopters.
- Develops and maintains relationships with local adopters.
- Organises local opportunities for collaboration.
- Provides local collaborative leadership, clinical leadership, project management and tailored support for spread and adoption across own region.

Source: Leack, 2017, p. 27
Our *leadership model* for spread and adoption

**Distributed leadership** devolves operational and clinical leadership and accountability to the local AHSN regions and down to the hospital teams. This empowers individuals to implement change and makes the best use of skills and contextual knowledge.

Source: Leack, 2017, p. 29
Our *methodology for spread and adoption*

**Building the collaborative**
Gain commitment from regional spread partners and key stakeholders (including adopters)

**Establishing measures**
Agree metrics, outcomes, data sharing and start collecting data to establish baseline

**Providing tailored support**
On-site visits and web conferences to support change in-between events

**Cross-AHSN and Local Collaborative events**
(IHI Breakthrough Series Model for Improvement)
Feedback progress, share learning, and celebrate successes. Includes QI training and leadership development

**Demonstrating impact**
Repeated data collection and review of outcomes, using measurement for improvement

**Continuous improvement & peer support network**
Sustain changes & continue to embed the care bundle for better care

Adapted from: Leack, 2017, KSS AHSN
Learning from our approach

Sadie, Programme Manager

- Working with multiple spread partners requires collaborative leadership skills, resilience and the ability to manage conflicting opinions.
- Distributed leadership requires people to ‘let go’ and to trust and empower others to do their job. You can’t do it all yourself.
- Good communication is essential to ensure all partners feel a sense of ownership in the delivery of the programme.
- Operational leadership (programme and project managers) is essential for enabling change. Spread and adoption at scale cannot be achieved with clinical leadership alone.

Tracy, Regional Sponsor

- When the ELC started all 3 AHSNs had different levels of surgical engagement: Wessex AHSN did not have a surgical project or clinical leads and we had to work quickly to get the basic building blocks in place.
- Working across 3 strong regional teams required patience, resilience and humour; it was essential to meet regularly to discuss challenges and to ensure we had a cohesive vision.
- We realised early on that the regions worked differently and that one size didn’t fit all in relation to collaborative working; relationships were key and the role of ELC project manager was critical to support this.
- The 8 Wessex hospitals really valued the opportunity to meet, connect and share during the regional and local ELC events and having regular data to review progress across the 8 teams gave clear focus and energy.
Learning from our approach

Anne, Regional Clinical Lead
- The clinical leads need to believe in the clinical model for change and be able to define the measurement strategy. They are the link between the central team and local hospitals.
- The more collaboration, the greater the learning. Different regions do things differently
- One size does not fit all. Understand the baseline and trust local teams to deliver. Need to balance centrally decided and local content of local learning events
- Share the success

Peter, Executive Sponsor
- As Exec sponsor my role was to try to empower others to excel and succeed, providing support and sometimes advice where this may be required.
- Distributed model helped to ensure local engagement, buy-in and ownership of the shared ambitions.
- To reduce unwarranted clinical variation in practice, the improvement journey teams will go on cannot be standardised…there is no one size that fits all.
- Collective decision making was important – this can sometimes be a challenge but enables local ownership.
Workshop objectives - revisited

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• To understand the processes involved in **a collaborative model for improvement** - we will share our learning from this approach.

• To understand the significance of **leadership development and measurement for improvement** for supporting spread and adoption of innovation.
Any questions for us?

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References

