



THE CLOCK IS TICKING...

**THE NHS NEEDS TO
CHANGE FASTER:
HERE'S HOW TO DO IT**

CONTENTS



Supplement editor
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OVERVIEW



Rapid Spread's creator wants to bring in a new, fast track way of changing the NHS: with no single ward or small scale pilots, and an unashamedly prescriptive approach
[Page 1](#)

TESTING



How the Rapid Spread team set about trying out their new tool for change – choosing two very different test sites
[Page 4](#)

OPINION

NHS change managers need to start looking beyond their traditional tools and embrace the tactics used to mobilise people in campaigns and social movements, says Helen Bevan
[Page 5](#)



CASE STUDY: SOUTHAMPTON



Southampton staff are encouraged by early results – and its nursing chief feels that Rapid Spread is here to stay
[Page 6](#)

CASE STUDY: YORK



Rapid Spread is improving patient care and patient experience at York Teaching Hospital
[Page 8](#)

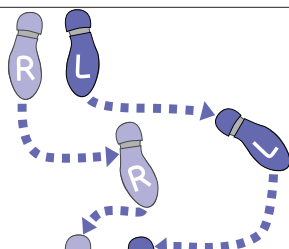
LESSONS LEARNED



Making sure staff believe in the change and collecting sound data will be vital to Rapid Spread's success, a review of the pilot suggests
[Page 10](#)

FAQs

A quick guide to Rapid Spread – and how to find out more and give feedback
[Page 13](#)



EDITOR'S INTRODUCTION

Welcome to this special supplement, which introduces Rapid Spread. It is a new idea that is now being tested in the NHS.

In essence, Rapid Spread takes the learning from work to reduce healthcare associated infections in the NHS and applies it to other improvement areas.

It is a way of introducing evidence-based change across an entire organisation and doing it quickly.

In this supplement you will read about how it was developed, the theory that underpins it and the lessons learned from the early tests, and hear directly from sites that have tested it.

On page 5 Helen Bevan presents the new leadership challenge – the need to incorporate mass mobilisation into our service transformation efforts.



It is an idea that is built into Rapid Spread.

On the last page there is a question and answer column that provides a quick check on some of the material in the supplement.

As the articles here make clear,

Rapid Spread is a work in progress but it could be ready for wider use soon.

So watch this space.

Daloni Carlisle,
editor



FOREWORD

CHRISTINE BEASLEY

Quality of care matters to patients and staff. It is now widely accepted that improving quality increases productivity, reduces inefficiency and saves money. The challenge for the NHS is to do this at a greater pace.

Much has been learned about how to make significant change as shown in the reduction in healthcare associated infections across the NHS. I know that this learning can be transferred to other aspects of quality and safety, which is why I am hugely supportive of my team's work to develop and test a new approach that can achieve a more rapid and sustainable improvement.

I am immensely grateful to the two sites, Southampton University Hospitals Trust and York Teaching Hospital Foundation Trust, which volunteered to test this new Rapid Spread approach.

Early results are greatly encouraging. I believe this approach can change culture and beliefs – echoing the culture change that led to zero tolerance of avoidable healthcare associated infections.

Rapid Spread is about igniting the passion to do things well and giving frontline staff the knowledge, tools and abilities to improve their professional skills. It helps them take the case for change to the trust board.

I would like to thank all those who have been involved so far in this work. It has been a tremendous effort but I think it has been well worth it.

Rapid Spread is still work in progress and, in that spirit, I urge you to read on and find out more about how this approach might enable your organisation to speed up change.

Christine Beasley is the chief nursing officer.



HOW TO STEP UP A GEAR

The creator of the Rapid Spread tool wants to end frustratingly slow ward by ward change and help trusts transform practice in just 30 days, as she tells Daloni Carlisle

Janice Stevens is in a hurry. As national director of the healthcare associated infection and mixed sex accommodation programmes, she has proved it is possible to make significant large scale change across the NHS.

Now she wants to take the learning about what made that work and use it to make other changes – only this time much faster. But she has only until next March to show it is possible.

So this summer she developed the Rapid Spread method. In essence, it gives clinicians a step by step tool for implementing an evidence-based practice across an entire organisation quickly. No tailoring the evidence to local circumstances, no single ward or small scale pilots, no chance for silos to develop while momentum fizzles out elsewhere.

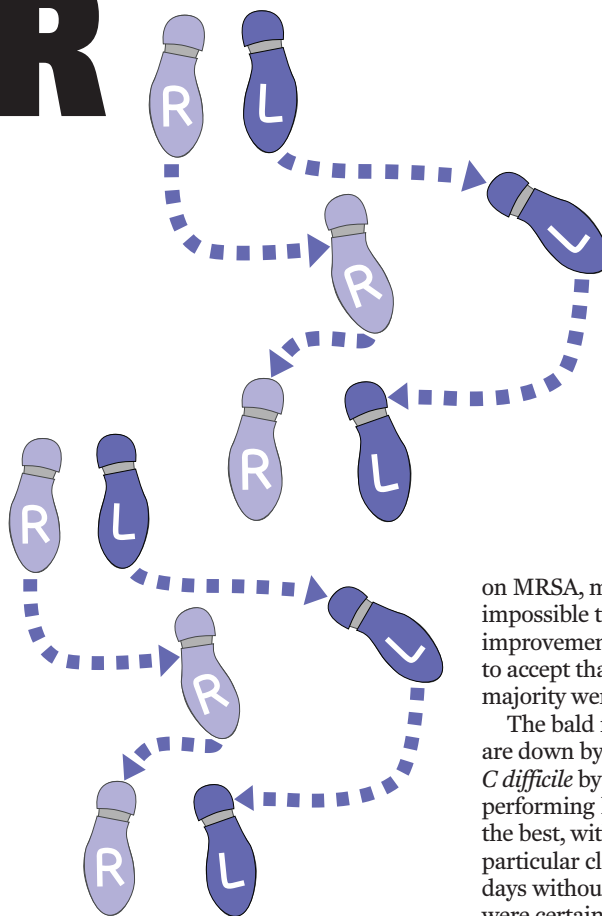
Ever one for a nice catchphrase, Ms Stevens sums up Rapid Spread as “30 wards in 30 days” – a phrase her team discourages in the name of precision.

Rapid Spread has been tested by two NHS trusts so far with promising results (see case studies starting on page 6 and lessons learned starting on page 10). The method has been modified and will be retested by three more trusts this winter. Ms Stevens very much hopes that by the time the infection and mixed sex accommodation work winds up in March 2011, she will have a workbook fit to offer to a wider NHS audience.

“Will it work?” she asks. “I know that whatever happens this method will help organisations to implement change at a greater pace than before – and that has got to be a bonus in these challenging times.”

While it is true that Rapid Spread has been developed quickly, it is not a rush job. Ms Stevens, a nurse by profession, has been leading the infection work since 2005.

She explains: “When we began the work



‘Why not get as many wards as you can in one go? We found that people can do things fast if there is a will’

Janice Stevens



on MRSA, most people believed it was impossible to make the level of improvement proposed. I was not prepared to accept that and I am delighted that the majority were indeed proved wrong.”

The bald figures are these: MRSA figures are down by 75 per cent since 2005 and *C difficile* by 55 per cent. Some of the worst performing hospitals at the start are now the best, with one Midland trust in particular clocking up over 465 consecutive days without an MRSA bacteraemia. There were certainly some lessons to be learned in the approach taken and Ms Stevens was anxious that they should not get lost.

The first was that change did not need to be slow and taken ward by ward.

“What we found in our work was that people are frustrated by the slow pace of change. It is not motivating. If we know what to do, why do we have to do it on two wards, four wards, eight wards and so on?”

“Why not get as many wards as you can in one go? We found that people can do things fast if there is a will.”

It is a notion that flies in the face of years of experience of quality improvement programmes. Typically, these programmes use PDSA (plan, do, study, act), small cycles of change and progressive roll-out.

“There is a role for PDSA when you do not have all the answers,” says Ms Stevens, “But in my opinion, if you know what you need to do, you need a method to just get on and do it.”

“What we need is a model that mitigates up front those elements that we know often prevent change happening.”

These too are well known: clinical staff will not adopt change if it is viewed as a management imposition; it will not occur if people are not skilled or given the equipment to make change; it will not occur if the leaders do not have the right leadership skills.

OVERVIEW

In the meantime, along came the quality, innovation, prevention and productivity programme.

"I am very mindful of the whole QIPP agenda and the need for significant improvement in quality and productivity," says Ms Stevens. "What we see is a lot of variation in practice in areas where there is a lot of evidence about what works well. Despite the evidence, people are still not adopting these practices.

"We need to make change happen faster, we need to take ideas that we already know work and we have to stop the notion that everything has to be adapted because somehow every organisation is so different. Work with healthcare associated infection showed that this was just not the case. Time is of the essence."

The High Impact Actions for Nursing and Midwifery identified by the chief nursing officer and NHS Institute for Innovation and Improvement in 2009 are a case in point.

She says: "We know both the human and financial cost of pressure ulcers, we know a good proportion are probably avoidable – much like healthcare associated infection was at the start – and we know how to prevent them happening."

Ms Stevens reasoned that if she applied what she had learned from the infection work about what is required to get adoption, reliability and sustainability, she could develop a model to achieve large scale change for any evidence-based care bundle.

The final element she added to the mix was the "hugely exciting" work now underway in the NHS to use "mass mobilisation" techniques that engage large numbers of people in a common aim.

This, then, is the genesis of Rapid Spread.

Ms Stevens explains: "This model starts with winning hearts and minds, but crucially it aims to mobilise people to a common goal and doing it with them. It then takes them through a very systematic set of actions over a six-week preparation phase prior to large numbers of wards all commencing on the same day."

The key to kickstarting large scale change is finding the will to change.

"You need to change beliefs," she says. "Change belief that it is possible, that you have a role to play, that you personally can make a difference. Making that shift is really important."

Only then can you influence behaviour.

"If you believe that washing your hands makes a difference in reducing infection you are more likely to wash your hands," Ms Stevens says.

But there is a third component. "You have

'Change belief that it is possible, that you have a role to play, that you personally can make a difference'

Quick thinking: care bundles for falls include actions such as making sure patients have a drink close to hand



to make sure that the policies, procedures and things you want to happen are in fact happening consistently," she says.

Underpinning this triumvirate of "belief, behaviour, be sure" are several other necessities for achieving large scale change: leadership at every level; data systems that can capture information; basic tools and techniques that are easy for staff to use (such as care bundles); and, finally, the recognition that some people or some areas will need more support than others. Ms Stevens is adamant Rapid Spread is not a project.

"It is an action model that gets people mobilised, energised and excited. It gets

things going but then makes sure they keep on going," she says.

It is split into two phases; the first is the six-week preparation phase, the second is the 30 days of doing it, with the intention to keep going. At each stage, a workbook sets out what needs to be done by whom and by when. It is literally step by step, with actions that can be ticked off when achieved.

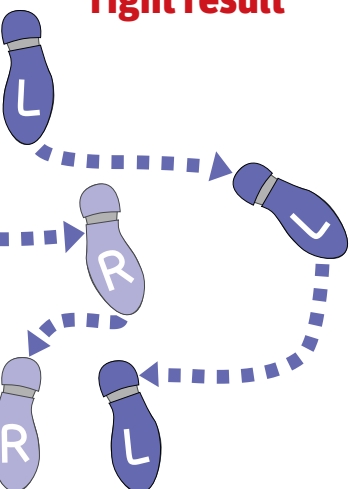
The preparation phase focuses on creating the case for change, getting the implementation team up and running, setting up data capture mechanisms, gaining trust board support and ensuring staff are up to speed with the clinical knowledge relevant to that change.





Easing the pressure: test sites have been using Rapid Spread to combat avoidable pressure ulcers

‘It’s a bit like a recipe. If you don’t follow one it’s more likely you won’t get the right result’



An important component of the preparation phase is an immersion event, which gathers together everyone who has a role to play in the change and mobilising their support (see page 10).

Next comes the 30-day “doing it” phase, in which wards implement the clinical bundle all at once, in one “big bang”.

“It is a period of intense activity – it’s larger scale with lots of people involved,” says Ms Stevens. “At the end of this phase, hopefully there will be some real sense of success, of pride, at the change made and a will to maintain the momentum.”

The test sites used two of the chief nursing officer’s High Impact Actions (HIAs) as their change initiatives – Your Skin Matters, which aims to eliminate avoidable pressure ulcers in NHS care and Staying Safe, reducing falls by older people in NHS care (see pages 6 to 9).

“We deliberately chose the HIAs for several reasons,” says Ms Stevens. “First, nurses have a reputation for getting a job done. With the HIAs there was such a swell of energy and enthusiasm that getting

people wanting to test Rapid Spread to implement them was not a problem. These are things that sit at the heart of what we, as nurses, are here to do.”

In each case, there is a care bundle. “Bundles are really good in this model,” says Ms Stevens. “They give four to six things that everybody has to do consistently and where the evidence shows that if they do them, then care will improve.”

In the case of falls, it is actions as simple as making sure patients have slippers at hand, have a drink within reach, are regularly asked about toileting. In the case of pressure ulcers, the actions are about use of mattresses and turning patients regularly.

There will doubtless be critics of the prescriptive approach in Rapid Spread who make the case for their particular area being special. But Ms Stevens makes no apologies for taking a prescriptive approach.

“Part of our belief is that it has to be,” she says. “It’s a bit like a recipe. If you don’t follow one it’s much more likely you won’t get the right result. The reason there are prescriptive elements is because they are important and they are not up for negotiation – that is not because we want to be busybodies but because, if the steps we set out are not done, you will not get adoption, spread and sustainability. You have to be up for every bit of it.”

At the time of writing, Ms Stevens and her team were tweaking the workbook in the light of learning from the first two sites and getting ready to start a second trial in three more NHS hospitals. Again, this is likely to be based on implementing the HIAs and will have nurses at the core.

She hopes that, by March, the workbook will be ready to launch to the wider NHS and be taken up not only by nurses but by other professions too.

“The model has the potential to be applied to anything that has an evidence-based bundle,” she says. “That could just as easily be venous thromboembolism or the World Health Organisation surgical checklist.”

Ms Stevens hopes Rapid Spread is an approach that will appeal to NHS trust boards, not least because their backing is vital if it is to reach its full potential.

She says: “The challenge to reduce costs means we have two options; one is the ‘cut and stop’ option. The other is to implement known good practice that improves quality and reduces cost. The latter must, though, be in the best interest of staff, patients and the NHS as a whole. I believe this work might play an important part in helping the NHS achieve this and provide a better patient experience.” ●

A CALL TO ACTION

Alison Hartley on how the Rapid Spread team set about testing its method by introducing new, 'high impact' ways of working at two very different sites

In November 2009 the chief nursing officer Christine Beasley identified eight High Impact Actions (HIAs) that, if implemented across the service, would make a substantial difference to quality, patient experience and cost.

A "call for action" was issued, with frontline staff asked to submit examples of high quality and cost effective care. Nurses and midwives responded by submitting more than 600 examples in less than three weeks.

These were then brought together by the NHS Institute for Innovation and Improvement in *The Essential Collection*. This highlighted some of the stories behind those submissions – providing details not only of what was done, but also, how it was done. This did not, however,

tell staff how to make similar changes in their own areas.

The HIA work provided the Rapid Spread team with the ideal basis for testing its new method for implementing change, which had been developed in spring 2010.

The trusts recruited to test Rapid Spread implemented two of the HIAs. They agreed that these offered a real opportunity to improve quality and patient experience – and the potential to improve efficiency. The two actions chosen were:

- **Your skin matters** – tackling and reducing pressure ulcers in NHS provided care
- **Staying safe** – reducing falls in NHS care.

These were selected for two main reasons. First, they are heavily influenced by nurses and could easily demonstrate the financial benefits of improvement. Second, in order to show improvement, the test needed good baseline data. This data needed to be sufficiently robust to measure the impact on falls and pressure ulcer numbers once changes had been implemented. The Rapid Spread

'The goal was to achieve adoption of the high impact action changes across 30 wards in 30 days'

team felt that data in both areas was likely to be good enough.

Choosing sites

The two test sites chosen to support the project's work and test the methodology were: York Teaching Hospital Foundation Trust and Southampton University Hospitals Trust.

The sites are very different in terms of organisation structure and size: York is a district general hospital employing around 4,600 staff, whereas Southampton, which employs 7,500 staff, is a university trust with a high proportion of patients who have complex needs. Choosing such different sites meant we could see if the method was applicable in different settings.

Senior managers at both sites were very keen to be involved and both hospitals already had change programmes underway in the HIA areas.

The Royal Wolverhampton Hospitals Trust was selected as the project's "learning site" (or control), which would assist with the designing of the methodology.

The test

The Rapid Spread methodology test ran over a 90 day phased period starting at the end of June 2010. For each HIA, a new way

of working was implemented based on evidence gathered across the NHS as part of the HIA project. The goal was to achieve adoption of the HIA changes across 30 wards in 30 days and produce meaningful, measurable changes.

Measuring success

In order to measure whether the methodology had been successful, a staff survey was conducted to gauge levels of adoption across participating wards. Before the changes were implemented each trust carried out a survey to gain a baseline; another survey was completed around four weeks into implementation to provide comparisons with the baseline.

As well as data regarding the adoption levels of the new ways of working, the impact of the changes on the numbers of falls and pressure ulcers needed to be included. Early indications are that the data will show a reduction in these (see case studies, pages 6-9).

The Institute for Employment Studies was involved, capturing some of the qualitative learning in an action learning project (see page 10).

Staff enthusiasm

The Rapid Spread team is grateful to all those who took part in these tests. The number of people who got involved – from staff nurses to chief executives and everyone in between – is testament to the importance attached to raising the quality of NHS care. ● *Alison Hartley was project manager for Rapid Spread in the healthcare associated infection and cleanliness division until October 2010*





The NHS needs to build its own social movement

We are at an extraordinary point in the story of the NHS. The triple challenge of changing demography, new technology and public expectations means that the NHS faces probably the greatest financial challenge in its history. An extraordinary leadership response is required.

Achieving the results we need depends on how our leadership community, clinical workforce and the people we serve answer an urgent call to action – a call to preserve and enhance what people value most about the NHS and to deliver safer, better care that makes better use of health service resources.

In essence, this is about mobilising thousands of people to build commitment to change at scale and organising to build leadership capacity so that the actions that people commit to are achieved.

We need change that is faster and broader than anything we have experienced before.

We must garner and build on all the change leadership capacity and experience that we have at present. At the same time, we probably require additional skills and perspectives.

Most of the methods, strategies and tools we use for NHS change come from a powerful body of “healthcare improvement knowledge” derived from experience in other industries and adapted for healthcare, built over the last 100 years.

But there is an additional, parallel body of knowledge about how to create change at scale that is rooted in the tradition of community organising, campaigns and social movements and in

learning from popular, civic and faith-based mobilisation efforts.

It is only in recent years that organisational leaders (such as those in the NHS) have started to recognise that this has significant potential to help formal organisations and systems to achieve their goals. It isn't an alternative to existing healthcare improvement knowledge but it enhances our ability to make change happen.

The community organising perspective teaches us that to mobilise, we need to motivate. Each person we want to engage has to make a personal and deep connection with the message, enough to inspire them to take decisive action. The key to motivation is understanding that values inspire action through emotion. Emotions inform us about what we value in ourselves, in others, and in the world, and enable us to express the motivational content of our values to others.

Critically, because we experience values emotionally, they are what move us to take determined action, not only to thinking we ought to take action.

To translate this bluntly, people in the NHS are far more likely to take action on quality and cost improvement if we frame it as a commitment and connection to the core mission of the health service. Essentially our efforts need to be about securing the kind of NHS that we want for our patients and that we would want to work in.

It is not a “soft option” to focus the message in this way. By connecting to our deeper purpose and collaborating around our collective mission, we increase the chances of unleashing the energy and

“

The community organising perspective teaches us that, in order to mobilise, we need to motivate

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creativity of our workforce and making more profound, wide-ranging changes more quickly and more sustainably.

One of the most effective ways that leaders of social movements and campaigns translate values into decisive action is through storytelling and narrative. It is a skill that we should all invest in during an era of quality and cost improvement.

Essentially, by developing skills in narrative we build our ability as leaders to draw from our own experiences and values to inspire others to join us in action. Stories communicate our values through emotions. It is what we feel – our hopes, the things we care passionately about, our commitments – that is most likely to inspire us with the bravery to act in the face of uncertainty.

One of our greatest leadership priorities looking forward is to build a quality and productivity strategy that is based on commitment to change rather than compliance with change.

In a world where traditional management levers such as hierarchy and structure are diminishing – and in an environment that is increasingly complex and uncertain – understanding how the leaders of the great social movements met the challenge of commitment building is essential learning for NHS leaders who want to create purpose for their workforce and deliver big changes fast. ●

Helen Bevan is director of service transformation at the NHS Institute for Innovation and Improvement. For more information and references for this article, contact mobilising@institute.nhs.uk

‘THIS IS THE CARE

Nurses at Southampton University Hospitals feel that the Rapid Spread initiative has freed them to focus on the fundamentals of care. By Kaye McIntosh

Day 50 of the rapid spread programme at Southampton University Hospitals Trust and ward manager Fiona Fordyce is buzzing: “We’ve not had a single hospital acquired pressure sore on this ward – and while we have had some falls, investigations have shown they were not avoidable.”

Director of nursing Judy Gillow is confident the scheme is making a real difference across the hospital. While it is too soon for statistically reliable data, there has been a drop in grade 3 and 4 pressure sores and avoidable falls. But Ms Gillow is a determined woman: “We will achieve zero hospital acquired for both,” she insists.

Southampton was invited to take part in Rapid Spread by NHS South Central. The trust has previously turned round performance on healthcare associated infections and so was an ideal site to implement this new methodology.

They were enthusiastic from the off: “We were keen to test this out – in fact very excited. We wanted to make this a success for our patients and our staff.”

Preparation was vital. The senior nursing team worked with the Department of Health team to understand the methodology and get the project management right.

They decided ultimately to aim for zero avoidable falls and pressure ulcers and identified project champions across the trust. They were keen to ensure the project would be about sustainable quality of care.

Deputy director of nursing Gail Byrne says: “We had to make the documents simple. We had one form for falls and pressure ulcers to make it practical for busy wards.” All materials were branded, such as the workbooks and ward project folders, helping to make the work highly visible.

At an immersion event in July, 40 matrons, ward managers, tissue viability nurses, sisters and healthcare assistants attended (see page 10).

“We needed to engage at every level, not make it hierarchical,” says Ms Byrne.

Ms Gillow told them the story of a patient who developed a pressure ulcer.

“It made people realise that they don’t want that happening to anyone in our trust. It gave them permission to go back to the fundamentals of patient care.”

It was essential to show people that the project was grounded in evidence. Nurses

KEY LESSONS

Ensure enough time is allocated to preparing and planning the initiative You need to have the aims, methodology, data and project management in place from the beginning

Get people involved early You need leadership and engagement at all levels, from senior staff to healthcare assistants. Feedback from matrons was they wanted to be involved right at the start in project design. This was key to success

Make use of your experts Tissue viability nurses, for instance, were a vital resource

Keep documentation simple So clinical staff don’t feel the project is a burden and can be sustained even when the ward is busy

Use branding Make the project identity clear on forms, workbooks, literature, and signs to raise awareness and act as a visual prompt

Celebrate success regularly Give clear feedback and thank people for their efforts

were taken through work done on falls in Ipswich and pressure ulcers in Wales, to show the approach was practical, not just a theory, and did work.

The team had discussions with a vascular consultant on defining avoidable and unavoidable ulcers. They didn’t want people to feel discouraged when patients developed problems that couldn’t be prevented – but also identified there could be learning. Equally the project allows ward staff to check whether the initial risk assessment has been carried out properly.

The leads explained the scheme at their meetings with ward teams.

“The last thing you want to do is tell people – you want them to work out this is a good practice and essential to good care,” says Ms Gillow, as it will speed up success.

Ms Byrne says regular meetings with project champions help people share successes and learning. Every patient who comes onto a ward is risk assessed. Laminated signs with clear symbols (a falling star for patients at risk of falls) are attached to their beds. Not just nurses but doctors, physiotherapists and occupational therapists can see if someone who has got up needs support.

Nurses “loved” the project’s two-hourly interventions, Ms Gillow says.

“It gave them permission to focus on the basics of good nursing care.”



‘The speed of the project was daunting but “gave us a focus and a pace that we had not had before”

She believes the scheme makes workload more manageable. Patients are having their needs met so this leads to fewer bell calls.

Nurses record their own results for falls and ulcers, with matrons validating and quality checking the data, which is uploaded weekly. Initially the number of pressure ulcers went up slightly – reflecting better reporting. They have since seen a decrease in grade 3 and 4 ulcers. Month on month, avoidable falls are dropping.

Ms Byrne says: “We have started to see improvements and we are confident we will see even more in this month. This gave encouragement to staff to continue.

WE WANT TO GIVE'



A falling star sign now clearly identifies Southampton patients who are at risk of falls



Change champions: director of nursing, Judy Gillow (right) with her deputy Gail Byrne

THE STORY ON THE WARD

The speed of the project was daunting but “gave us a focus and a pace that we had not had before,” says Ms Byrne. “The ‘big bang’ approach helped to engage people, and added a bit of healthy competition.”

Ms Gillow believes this quality initiative is sustainable and says this is “what we should be doing anyway as part of our regular routine”. The danger is that after initial enthusiasm, results may hit a plateau.

“You need to reassure people that we can continue to improve and you need to celebrate success – that was a key lesson we drew from our previous work on MRSA,” says Ms Gillow.

Positive feedback from patients was important. The trust is planning an event to thank everyone, which “will involve all the ward teams, get people to share their stories and make sure they know what they have done is fantastic”.

The project is looking to the next 90 days to ensure improvement continues. There are plans to use this methodology for other improvement initiatives. ●

Ward manager Fiona Fordyce has been on shift since 7.15am. It is now 10.30am and she has “hardly heard a call bell this morning”. That is because patients know they are being looked after and their needs are being met.

Patients are risk assessed immediately they come onto the 18-bed trauma and orthopaedic ward.

“We know very clearly on every shift who are the patients at risk, which I couldn’t have told you accurately you six months ago,” says Ms Fordyce. “We have a much more efficient workload now. As the numbers of pressure ulcers reduce it frees up time to care.”

Ms Fordyce and her matron, Tina Raybould, came back to the ward full of enthusiasm after the immersion event: “This was about the essentials of nursing care. Not that we’d forgotten that but other priorities take over and it’s easy to lose focus.”

Ms Fordyce and Ms Raybould gave a presentation to the ward team and “were overwhelmed by the really positive response”.

Although there were questions about how staff would fit in the two-hourly interventions,

people saw results quickly and knew it was right for patients.

One patient, Daisy, a 94-year-old, came in with a broken neck of femur having fallen at home. She did not fall again during her whole 11 days on the ward. “Staff were really proud.”

Daisy spent some time on another ward. But when she came back to this ward, she went a further 25 days without problems.

“People really grasped the message that ‘Daisy didn’t fall’,” says Ms Fordyce.

Nurses cannot always give one to one supervision but clear signs on patient beds means everyone on the ward is alert.

“Our medical colleagues, physiotherapists and occupational therapists can see the falling star symbol – it means any member of staff can know the patient is high risk and can immediately attend to their needs.”

Ms Fordyce is convinced Rapid Spread works: “I’m telling all my friends about it, in other trusts and in the community. This level of care is what we want to provide.”

Now the plan is to roll out across the whole hospital.

‘WE CAN’T GO SLOW’

York hospital chair Alan Rose says his trust can’t afford ‘ponderous’ change – which may be why he and the staff have embraced Rapid Spread. By Alison Moore

Alan Rose knows more about hospital mattresses than your average trust chair. York Teaching Hospital Foundation Trust tested Rapid Spread as a way of introducing a radical programme of changes to prevent falls and pressure ulcers. The aim was to enable nurses to introduce evidence-based care bundles – and to do it as quickly and efficiently as possible across the whole organisation.

But, says Mr Rose, the use of Rapid Spread to promote a “big bang” approach exposed flaws in the ordering system for mattresses. This had been an irritation to many staff for a long time – but was never a significant enough problem for any one person to address.

It is one reason why the trust is keen to use Rapid Spread again.

York’s Rapid Spread test followed the methodology provided by the Department of Health’s healthcare associated infection and cleanliness division improvement team, and, with the same on-site support, it set up delivery teams, carried out stakeholder analysis and engaged senior leadership, all in preparation for 28 July 2010.

Much of the delivery team’s work focused on gaining assurance, providing support and unblocking barriers to success.

Midway through the preparation phase, an immersion event was held, bringing together ward sisters and matrons from across the hospital and setting out not only the case for change but also how they were all going to implement the changes (see page 10).

“It was a fabulous event,” says chief nurse Libby McManus. “It was an opportunity for all of us to reconnect with our passion for safe and effective care.”

The sisters had the job of preparing their staff for the changeover – and within days the hospital was buzzing about the initiative.

The designated day for the great changeover was July 28, with new documentation to support the care bundles coming in

KEY LESSONS

Identify and involve stakeholders early.

Increased awareness and greater reporting may make it appear that things are going backward – staff need to be given clear messages about why this is happening and encouraged to continue to report

Large scale implementation will reveal problems that a conventional pilot would not have done.

These need to be addressed. Some of the documentation and procedures needed to be refined in the later stages of implementation

Communicating and recognising achievement is important at all stages

across the hospital, which meant that every patient had to be reassessed.

“We knew it was going to be a tough day but we had every confidence that staff would do the right thing,” says Ms McManus. “The initial changes on day one were a real stretch. People worked exceptionally hard to ensure that within 24 to 48 hours everyone had adopted the new practices outlined in the care bundle.”

During the follow-up period, ward sisters have been carrying out random checks on patient notes to see if they were being assessed and whether the care bundle, if needed, was being carried out.

“Our business now is about sustaining the change,” says Ms McManus. “We have monthly meetings with our ward sisters and matrons to feed back and hear about how things are going.”

With just a couple of months’ data available at the time of writing, the team was keen not to make too many claims for success. But there are very encouraging trends.

Generally, falls and pressure ulcers are being reported in greater numbers – which indicates staff are focused on this work. This has needed careful handling with the staff to explain it is not viewed as a failure. The




number of days in between the development of pressure ulcers is steadily increasing and falls are reducing.

The positive message is that if a patient does fall the trust is clear that an assessment has taken place and a bundle of care applied – evidence that the trust has done what it can and should do. The ulcers that have occurred are the least serious type, are being managed effectively and are therefore not developing further.

In both cases, the cost of dealing with the consequences of these has plummeted – in August, for example, the costs of dealing with falls was just over £5,000 compared with an average of over £26,000 before the change.

York is also looking at some of the learning. Communicating the coming changes to all staff – including those on holiday, sick or maternity leave, as well as agency staff – was also challenging.

Ms McManus says in future she will consult with matrons much earlier to plan and manage implementation, and increase the involvement of key medical staff and other experts. All proposed changes and learning have been fed back to the DH to influence application of the methodology in more organisations.



Rapid roll out:
chief nurse Libby
McManus with
colleague Jacky
Hesseltine

‘Where there is something that is already tested and we can trust it, a rapid roll out works’

The third part of the initiative is refinement: for instance, an adverse incident form on pressure ulcers was revised a month after the start of the scheme to allow multiple ulcers to be recorded on one form rather than several. This reduced the time needed to fill it in.

In addition, some reassessments, which originally had to be done every day, were later reduced to every three days.

“It is a very iterative process which can work if the culture is supportive of that,” says Mr Rose. “If there was a problem on the ward we did not want it hidden and we talked about it openly.”

Overall, the rapid introduction of the changes is seen as a success. Mr Rose points out the real benefits to the hospital – it is not only improving the patient experience

and patient care, but there are cost benefits. He believes the Rapid Spread approach helped to create excitement about the changes.

“We have ruffled some feathers, had to amend some of our paperwork and miscued a few things – but the benefits have outweighed the more traditional roll out approach.

“In the environment we are in, we can’t afford very slow ponderous roll outs,” he says.

Looking back Ms McManus says she would absolutely use the method again – but stresses that it has to be used on things with the right focus and that timing is critical. The time commitment needed to introduce change in a “big bang” approach did mean that some other initiatives had to go on the back burner temporarily.

However, had the changes been brought in using slower methods, she says, “we might still be looking at results with just one ward, which is far less convincing in terms of the nursing contribution to the quality, innovation, prevention and productivity programme”.

She says: “Where there is something that is already tested and we can trust it, a rapid roll out works.” ●

THE STORY ON THE WARD

Sister Juliet Robinson has not seen a pressure ulcer of grade 2 or above develop on her ward for 76 days and, not surprisingly, she is delighted.

Nurses on her general elderly acute ward had come to accept that there was always a risk of seeing patients develop ulcers or seeing existing ones worsen; in February 2010, for example, the ward had 12 patients with grade two or worse ulcers.

That is no longer the case. The use of Rapid Spread to introduce regular risk assessment and the use of a care bundle for those identified as being at risk has made a significant difference to nurses’ beliefs and to the number of pressure ulcers that have developed. Although there have been cases of grade one – the least serious – ulcers since the changes, none has developed beyond this.

Ms Robinson says there was enthusiasm for the changes among nurses, who found it upsetting when patients developed ulcers.

“If one of our patients developed a pressure sore tomorrow, we would be very upset,” she says.

The Rapid Spread approach has had benefits – some of the broader issues such as availability of mattresses have been addressed, and when agency nurses come onto the ward it is increasingly likely they will be familiar with the assessment and care bundle, and will be able to implement it.

The sense that the ward was not doing it on its own – that the whole hospital was involved – was also important.

START BY WINNING

Engaged and motivated staff, good data and robust science are all crucial if the Rapid Spread method is to succeed. By Valerie Garrow

The Institute for Employment Studies was asked to capture learning from the Rapid Spread pilot that was undertaken at Southampton University Hospitals Trust and York Teaching Hospital Foundation Trust from June 2010 to introduce actions aimed at reducing pressure ulcers and falls.

This was done through real time learning with the sites. It was not a formal evaluation but an attempt to capture very early on what was working and what needed to be refined.

We made an initial visit to the sites to meet the teams implementing Rapid Spread. Thereafter we carried out longitudinal learning visits between the first and second 30 day periods – that is between the preparation and implementation phases – and then again at the transition to the third 30 day period when the learning and refining period starts.

During these visits, we conducted interviews and focus groups with different stakeholders, including the executive lead, implementation leads, matrons, the delivery team, portfolio managers, staff nurses and specialists. We also made regular telephone calls to the sites and drew on a range of other resources including diaries and the minutes of meetings.

This enabled us to develop a detailed picture of what worked in this first trial, as well as what may need refining in future iterations of the Rapid Spread methodology and workbook.

Emerging benefits

The first point to make is that Rapid Spread was widely supported in both pilot sites. The system wide approach was seen as a good way to introduce good practice that is evidence based. The advantage over a singular or segmented approach was that people could share knowledge and learning. The immersion event (see box, page 12), provided context and understanding.

Overall, there were a number of benefits. Both trusts commented on the sense of collaborative working and team spirit that had been generated through using the method. Southampton reported that Rapid Spread gave them the courage to go for a “big bang” approach with focus and pace.

Rapid Spread was also seen as a balance between “what’s comfortable” and “pushing a bit” and staff commented on the excitement of implementing change within

a 90 day period.

In both trusts, Rapid Spread has shown that nurses can successfully lead change – it has been very important for raising the nursing agenda.

The timelines were also seen as useful in driving the project forward and the commitment of a senior team has helped to remove barriers and unblock systems. Benefits described include having clear milestones and clarity regarding what needs to be done. The daily plan of activity was also welcomed.

Rapid Spread builds on and formalises existing good practice, creates continuity and provides consistency so staff feel confident handing over. It also develops the change management skills of those involved in planning and implementing the methodology.

Staff also see benefits in protecting themselves against litigation. The method raises awareness of data quality and collection and encourages a positive reporting culture.

KEY LESSONS FROM THE PILOT SITES

Change readiness

Rapid Spread will work best in those organisations that are ready to change and already have some expertise in change management. Both pilot sites were selected for their readiness to change and had firm commitment from senior leaders.

The process involved in introducing Rapid Spread requires a reasonable level of improvement expertise and some understanding about engaging staff through change. This is recognised in the methodology. As an example, delivering the immersion event and the cascade process that transfers knowledge to a wider group requires a culture that is open to change and leaders who have both the skills and energy to deliver it.

The implementation roles are key too but require the sponsorship of the trust’s chief nurse if they are to succeed. These roles need a lot of energy and a lot of skill in change management.



Preparation

Preparation is key. This is the point at which those involved must win the hearts and minds of all stakeholders and engage them in a process that will change the way they work and expand their skillset. There will be benefits for staff as their processes become more efficient, and for their patients as care is improved.

The methodology is split into 30 days’ preparation, 30 days’ implementation and

HEARTS AND MINDS



governance board meeting by two days at the start of the 30 day preparation phase. This means that 28 of the 30 days then pass before the next meeting. Other practical issues include having to book meeting rooms and find space in senior leaders' diaries, which are often booked up more than a month in advance.

Baseline data

Good baseline data is vital. Although its absence does not prevent improvement, it does prevent the measurement of improvement.

A key outcome of implementing Rapid Spread at both sites was raising awareness of data. It exposed how ward staff often lack access to data, for example regarding the number and type of falls or pressure sores that are prevalent. Access to this kind of information will now become the norm.

As an example, data to show the incidence of falls is now displayed on the wards in York, which will help ward staff take ownership for monitoring their own progress and engage patients and carers in considering their own role in reducing falls. While recognising that "bad things can still happen in good places" ward staff have begun to take enormous pride in working for sustained periods with no falls.

Engaging all the stakeholders

Getting the stakeholder engagement right is very hard if it has not been done before – a key learning point that reinforces the need for skills in change management. Those who are familiar with change will understand that there are always more stakeholders than originally thought and the repercussions of not involving them appropriately can be serious.

The importance of stakeholder involvement should be highlighted in the methodology, with sufficient time allocated to ensure it is comprehensive and allows for a detailed strategy that takes into account the different requirements of all the interest groups involved.

Experts

Leading on from stakeholder engagement is the way in which experts are brought into

Supporting change: staff need to believe that actions – such as ensuring patients at risk of falls have water and slippers to hand – will be effective

‘Rapid Spread will work best in those organisations that are ready to change and already have some expertise in change management’

30 days' learning and refining. The preparation phase could benefit from being slightly longer – perhaps six weeks instead of the tested four – and there are several reasons for this.

The pilot sites suggested that an initial period of one or two weeks was needed for the lead to understand and appreciate the implications of the project before the preparation phase actually started.

There are also some practical issues to bear in mind. Many communication cycles in NHS trusts are 30 days; as such it is possible to miss, for example, a clinical

LESSONS LEARNED

‘Before implementing Rapid Spread, the science behind the initiative needs to be proven and convincing’

Rapid Spread. Although the methodology focuses on engaging frontline ward staff in making evidence based changes to improve practice, there are also experts to consider. In the pilot, these experts were the tissue viability nurses and the falls specialists. There was some evidence in this learning exercise that these experts should be involved in the delivery teams so they can become “resident experts” and be used as leaders.

Winning the hearts and minds of matrons

The matrons proved to be a pivotal group in the success of Rapid Spread. Their ownership is vital in cascading and sustaining the initiative. Where they are involved in action planning, they start to see themselves as leaders, who are engaging their staff. It is important that they are involved from the beginning so that they can help with the design, preparation and delivery of the scheme.

Sustainability

The third and final 30 day phase in the Rapid Spread methodology is where the change is embedded. The current view from the sites is that the overall timeframe for this may need to be longer than 30 days, with evaluation of the outcomes taking place from six months onwards.

The pilot sites also suggested introducing the NHS Institute’s sustainability model during the preparation phase rather than right at the end. This would ensure it is built into the design from the start.



Lead role: Rapid Spread shows that nurses can lead big changes

Accepting the science

Rapid Spread involves using a methodology to implement a proven change that does not need to be piloted or refined for local circumstances. Therefore, before implementing Rapid Spread, the science behind the initiative needs to be both proven and convincing.

Lack of confidence in the science may cause doubts and cynicism if the results are not successful. As such, it is imperative that the original research is reliable and learning from it must be shared fully – perhaps through a site visit. It is essential that resident experts feel secure and comfortable with the science.

Knowing when to use Rapid Spread

Having a specific method to work with made the Rapid Spread initiative feel different to those involved, compared with previous change projects. It is, however, a labour intensive process in the short term and, therefore, may only be applicable to high priority projects. ●

Valerie Garrow (right) is associate director at the Institute for Employment Studies



IMMERSION EVENT – WHAT’S IT ALL ABOUT?

The immersion event is a focused staff session aimed at taking people collectively on a journey from initial awareness of the initiative through to understanding and full commitment to spreading it. The event was deemed critical to achieving the rapid adoption and spread of new ways of working.

In the past, information about such change has typically been disseminated ward by ward over a longer period. However, this is intended to be a one off large event that involves all key line managers of staff tasked with making the changes.

For those changes that are nurse led, attendees will be matrons and ward sisters from across the

organisation. The event should also involve experts relevant to the changes being made.

A key component is communicating the evidence based case for change in order to win hearts and minds so staff are driven to act and support the changes. A compelling case for change should provide a clear understanding of what is being changed, why those changes are being proposed and the positive impact those changes could have.

The immersion event is also intended to help staff engage in: ● Identifying stakeholders and then helping to structure exactly what needs to be communicated to those stakeholders and at what stage in the process.

● Problem solving – it is important at this early stage that staff can express concerns or talk about possible barriers. Some of these problems may be resolved during the event but others require action to be agreed and taken afterwards. It is important that the event provides an open atmosphere, where staff feel comfortable about discussing any concerns they may have.

● Action planning – an opportunity to sit with colleagues, think through and agree what actions will need to be taken in their respective areas once they leave the event to support the changes being spread.

A critical success factor in Rapid Spread is injecting energy and

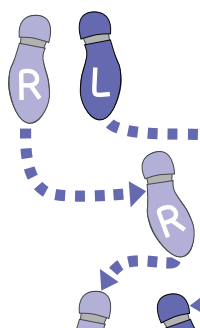
enthusiasm for change into all of the participants. Nurse leaders should feel excited and energised and leave the immersion event fully equipped to go out and make the changes happen within their wards. Having been part of the event they should feel confident communicating the case for change to other staff in their area.

Overall, a successful immersion event should create change champions and start the process of establishing leaders at all levels of the organisation to push the changes forward.

Alison Hartley was project manager for Rapid Spread in the healthcare associated infection and cleanliness division until October 2010

YOUR QUESTIONS ANSWERED

A quick guide to Rapid Spread, how you can find out more and how you can give feedback on the articles here



What is Rapid Spread?

It is a methodology to help the NHS introduce evidence based care bundles at scale and at pace – that is across a whole organisation, quickly.

How does it work?

The methodology is set out in a Rapid Spread workbook that gives step by step instructions on what an organisation needs to do, and when, in order to implement an evidence based care bundle using a big bang approach. It is, above all, a practical tool for implementing change.

Why is it different from other methodologies?

It rejects the notion that change should be implemented incrementally, with small scale pilots carried out before a wider roll out.

Can any organisation use it?

The learning so far indicates that using Rapid Spread requires some change management skills in senior leaders and middle managers as well as a culture of change within the organisation.

Why is it needed?

The NHS has to deliver significant savings in a short time, as well as ongoing improvements in quality and productivity by implementing evidence based practice and eliminating variation. Rapid Spread offers a tool for doing just that.

Is it just for nurses?

No. In the first pilots, trusts used Rapid Spread to implement care bundles in two of the High Impact Actions for nursing and midwifery. However, it could be used to support any health profession, or group of professions, implementing any evidence based intervention.

Is it just for large acute hospitals?

No. Although it has been tested only in large acute hospitals so far, it has been designed so that it can be used in any NHS setting.

Can it be used for any change?

One of the early steps in Rapid Change is making the clinical or compelling case for change. Therefore, any change implemented using Rapid Spread will need to be high on the clinical agenda and have a strong evidence base.

Is it only for changes that affect the whole organisation?

No. It could be used in one area, for example maternity services or theatres, but its key features are scale and pace.

How long does it take?

Rapid Spread was initially designed as a 90 day action programme with 30 days of preparation, 30 days of implementation and a final 30 days of learning and refining. This has changed as learning from the pilots informs developments.

What is the role for the trust board?

Rapid Spread – like all change management – requires the engagement and backing of senior leaders. It also requires some up front resources. Boards will need to commit to both.

What underpins Rapid Spread

Rapid Spread is based on the cumulative learning from large scale evaluations of quality improvement programmes in the NHS and on the experience of the Healthcare Associated Infection and Cleanliness Division in the Department of Health between 2005 and 2010. It also takes in newer work on mass mobilisation techniques that can be used to engage clinical staff in making change.

When can I use it?

Not just yet. It is still a work in progress. Testing of a refined methodology is now underway and the learning from this will be distilled by March 2011. It is hoped that the workbook will be made more widely available after that.

Does it work?

The learning experience from two pilot studies in 2010 indicates that it can deliver rapid change across multiple wards in large acute hospitals. Three more pilot schemes are underway and expected to finish by March 2011.

Where can I find out more?

If you want to know more about Rapid Spread or provide feedback about the articles in this supplement, please contact janice.stevens@dh.gsi.gov.uk

