Scaling up - implementation ‘writ large’ or something distinct and different?”
The plan!

1. Tackle the terminology
2. Have a go at answering the question – is scale up something distinct from implementation?
3. Share some recent challenges to scaling up from a social science perspective
‘Activity that results in an intervention being replicated across multiple sites. Scaling, which is a subset of spread, refers to an initiative to replicate an intervention specifically through a higher-level organisation or geographical entity (such as a professional body or government agency); but spread can also happen through horizontal connections between adopters, without the involvement of a higher-level entity...we sometimes use both terms together, though more commonly ‘spread’ is used as a shorthand for both.’
Clarifying terms

Terms are used interchangeably:

A-Scale up

With (subtly different meanings)

1 After a defined period of time ‘a thing’ continues to be delivered and produce benefits

2 The ambition or process of expanding the coverage of health interventions.”

B-Spread

3 The ability of a health intervention shown to be efficacious on a small scale (or under controlled conditions) to be expanded under real world conditions to reach a greater proportion of the eligible population, while retaining effectiveness
...and then a new term comes along!
“Deliberate efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis”

Norton, 2012
Why is this such an important topic?

How to spread new ideas and effective practices from one organisation to another to improve care and reduce unwarranted variations in performance is one of the central challenges facing the NHS.
The Evolution
Of Informing Policy and Practice with Evidence

1 Dissemination
What can we publish?

2 Relational
Do we understand the priorities of practitioners?

3 Systems
What needs to be in place to be a more evidence-using organization?

A shift towards a science of implementation

www.healthcare.ac.uk
Diffusion of Innovations Model
Everett Rogers. 1962

- Innovators: 2.5%
- Early Adopters: 13.5%
- Early Majority: 34%
- Late Majority: 34%
- Laggards: 16%
**Figure 3.** Conceptual Model for Considering the Determinants of Diffusion, Dissemination, and Implementation of Innovation in Health Service Delivery and Organization, Based on a Systematic Review of Empirical Research Studies
A small slice of individual and organisational factors

Facilitators

- Contributes to professional development and meets organizational goals
- Improves working relations
- Stable organization

Barriers

- Nurses, or their colleagues, considering the innovation to be incompatible with their role
- Organizational infrastructure and changes

QUALITY IMPROVEMENT

Spreading and scaling up innovation and improvement

Disseminating innovation across the healthcare system is challenging but potentially achievable through different logics: mechanistic, ecological, and social, say Trisha Greenhalgh and Chrysanthi Papoutsi

Trisha Greenhalgh professor, Chrysanthi Papoutsi postdoctoral researcher
So can we spot any differences?
Two examples

Patient and Family Centred Care (PFCC)
Enabling Self-management and Coping with Arthritic Pain using Exercise

12 sessions: 2 per week for 6 weeks
Group: 8-12 people start/end together
Each session combines education + exercise
In line with NICE clinical guidance

Education
≈20min per session
Facilitated group discussion

Exercise
≈40min per session
Progressive & individualised
Escape pain at scale

Role of a network in creating physical and digital spaces to support scale up

www.healthcare.ac.uk
Patient and Family Centred Care at scale

An evidence based service improvement intervention with 6 components: including care flow mapping and shadowing

Shadowing
‘Observation leads to empathy, which, in turn, leads to a sense of urgency and action’

www.healthcare.ac.uk
PFCC at scale

- Retain key programme elements including shadowing
- Lighter touch project support
- Clear guidance re what needs doing when
- Adding in a new support mechanism: peer to peer coaching
STETLER MODEL

Phase 1: Preparation
- Create a team
- Assess needs
- Explore evidence
- Examine usability of interventions
- Consider implementation drivers
- Assess fit and feasibility

Phase 2: Validation
- Acquire resources
- Prepare organizations
- Prepare implementation drivers
- Select and prepare staff
- Make administrative changes

Phase 3: Comparative Evaluation / Decision Making
- Assess and adjust implementation drivers
- Manage change
- Assess fidelity
- Deploy data systems
- Initiate improvement cycles

Phase 4: Translation / Application
- Monitor & improve implementation drivers
- Achieve fidelity & outcomes
- Monitor organization and system supports

Phase 5: Evaluation

2 - 4 Years
Exploration
Understand and Decide

Installation
Plan and Prepare

Initial Implementation
Test and Refine

Full implementation
Maintain and Grow

Scale-up and sustainability

Adapted from: http://improvingsystems.ca/
www.healthcare.ac.uk
Since everything is now about the dark side...

Emphasis on push....
A new form of colonialism?

• Whose knowledge?
• Who decides which outcomes matter?
• Scope for adaptation and creativity?
BMJ Global Health wishes to participate in the development of implementation science but with a focus on equity and on a better adaptation and/or creation of theoretical, conceptual and methodological approaches in the context of LMICs. In fact, a review of writings (1933–2003) concerning research on the implementation of public policies shows that only 4% concerned Africa, 2% Latin America and 15% was on health. The author of this review clearly highlighted ‘the ethnocentric bias in implementation studies’. This observation was confirmed in another analysis (1986–2006) of research in public policies in the field of health promotion: ‘all the most authoritative conceptualizations mentioned here were modelled on Western-style democratic governance systems’. Two rapid bibliographic searches using Pubmed
Scale up and indigenous communities

‘Many of the failed programmes in the past have been designed and delivered ‘top down’, through external contractors’

Head and DiFrancesco 2019
Closer to ‘home’

Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental ‘Health’

Diana Rose¹,²* and Jayasree Kalathil³

¹Service User Research Enterprise, Department of Health Service & Population Research, King’s College London, United Kingdom
²King’s College London, United Kingdom
³independent researcher, United Kingdom
When there’s no co-design you can be sure that implementation, embedding and integration will never happen. What gets normalised is chaos. politi.co/2l1nRNe via @politico

Lost in translation: Epic goes to Denmark
The software system created “indescribable, total chaos” at Danish hospitals.
politico.com
Implementing Evidence-Based Child Welfare at Scale: The New York City Experience
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[Diagram showing the distribution of adopters over time]
To sum up:

Scale up ≥ Implementation

Scale up is positioned as a later stage activity, but needs consideration right from the start.

Important that we don’t overlook the potential dark side of scale up and our own roles as implementers and evaluators.