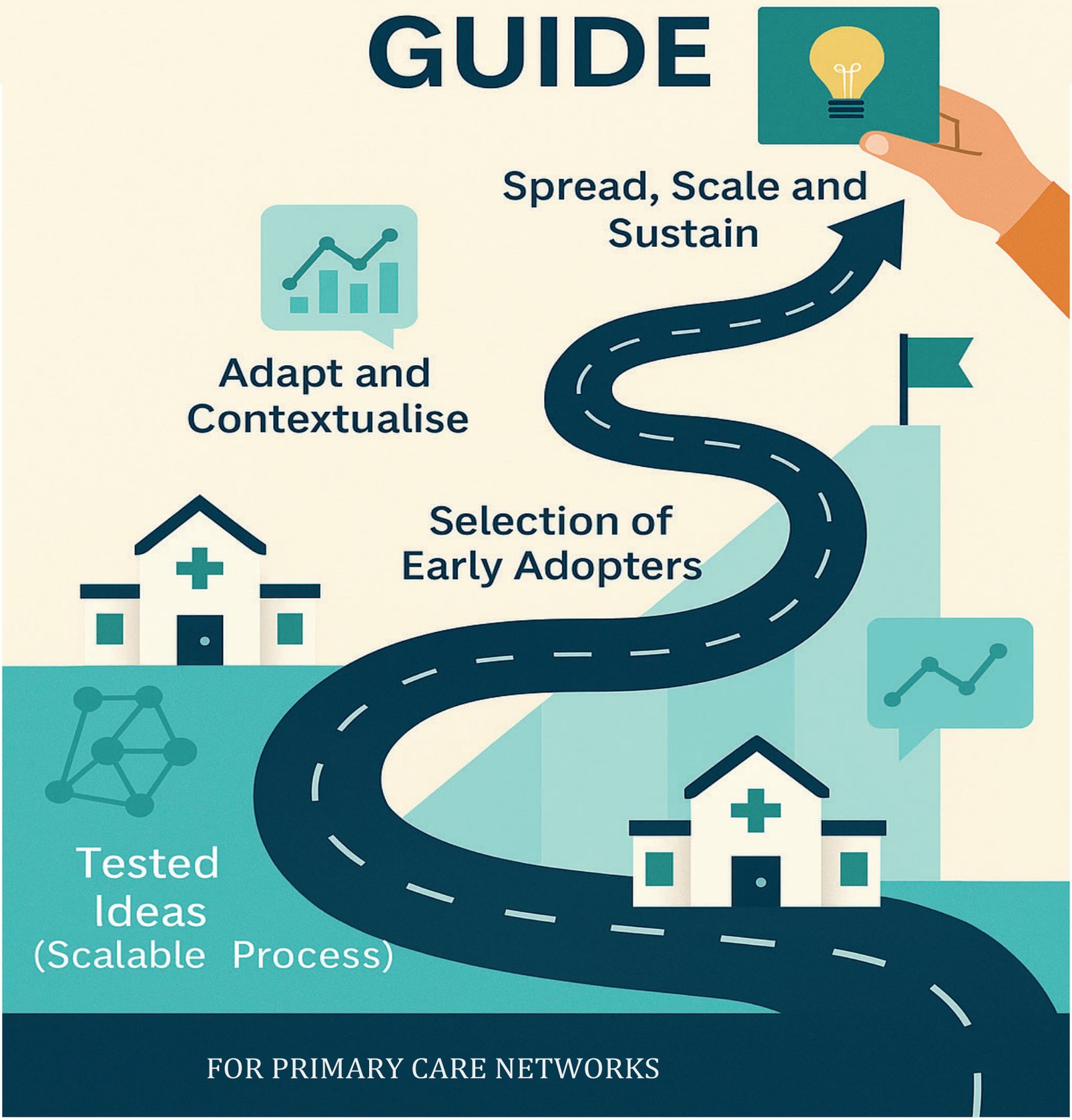
NiU
National Improvement Unit
Singapore

SPREAD & SCALE GUIDE



FOR PRIMARY CARE NETWORKS

Effective Clinic Selection for Spread

For diabetic foot/eye screening and vaccination efforts

1 Set the Purpose

Focus on early adopters/ early majority clinics for the two processes

2 Gather the Data

Collect population volume, baseline rates and readines scores

3 Apply Readiness/ Priority Scoring (RAG – Red, Amber, Creen)

Score leadership committment, capacity, and population neerd

4 Combine the Two Lenses

Identify clinics in early adopter and early majority

5 Classify by Rogers' Diffusion Curve (Relative Adoption)

Rank clinics and apply adoption categories

6 Use Data to Spot 'Room for improvemen'

Prioritize higher-volume clinics with low / moderate uptake

7 Build Transparency & Buy-In

Share dashboards, highlight top clinics to encourage adoption

8 Take Action in Waves

Select clinics in stages, provide targeted support

Purpose of a Spread & Scale Guide

The Spread & Scale Guide provides a practical roadmap to implement proven improvements from isolated successes into system-wide, sustainable impact. Rooted in quality improvement and implementation science, it equips teams with the tools to select scalable processes, engage early adopters, adapt innovations to local contexts, and embed change across primary care networks. Its purpose is simple: to transform small wins into lasting, population-level benefits.

This guide is designed to:

1. **Bridge Improvement and Implementation Science**
   It combines principles of quality improvement with frameworks from implementation science to ensure that successful ideas are replicated but also adapted and sustained in diverse contexts.
2. **Provide Practical Tools for Teams**
   By offering structured steps, checklists, and templates, the guide equips teams with the tools they need to select tested ideas, identify early adopters, adapt processes, and drive spread in a systematic way.
3. **Support Organisational Alignment**
   It aligns spread and scale activities with system priorities, leadership goals, and population health needs, ensuring that efforts are strategic and impactful.
4. **Build Confidence in Change**
   The guide demystifies the process of spreading and scaling, helping teams feel prepared to operationalise change, measure progress, and learn quickly from successes and challenges.
5. **Enable Sustainability**
   Finally, this guide emphasises that to spread and scale an intervention is not once-off. They are continuous cycles of learning, adaptation, and reinforcement that embed new practices into the fabric of care delivery.

Context & Rationale

Health systems are under increasing pressure to deliver high-quality, equitable care to growing and diverse populations. While many innovative ideas and quality improvement initiatives show success in individual clinics, too often these gains remain isolated. The result is a patchwork of improvement rather than system-wide transformation.

Spread and scale are essential to bridge this gap. Spread ensures that proven practices are replicated in new settings, while scale embeds them into routine operations so entire populations benefit. Together, they move improvement work from promising pilots to lasting, measurable outcomes.

In primary care networks, this is especially urgent. Clinics face rising chronic disease burdens, vaccination needs, and equity challenges, yet resources are limited. By spreading and scaling tested processes—such as diabetic screening or vaccination workflows—networks can accelerate adoption, reduce variation, and maximise impact for patients.

This guide aims to support this need. It draws on the principles of quality improvement and implementation science to offer practical tools that help teams not just do more, but do better, together. With clear steps, adaptable frameworks, and ready-to-use templates, it provides a structured pathway for achieving reliable, sustainable change across multiple sites.

Definitions & Key Concepts

To ensure a shared understanding across the Primary Care Network (PCN), this section defines the key concepts that underpin the guide.

Spread

The active, intentional process of replicating a tested improvement or innovation in new sites. Spread focuses on adoption across multiple clinics so that effective practices move beyond isolated pilots.

Scale

The process of embedding a proven practice into the system's standard operations to achieve population-level impact. Scale ensures that improvements are adopted but also sustained and normalised.

Waved/Sequential Spread Approach

Instead of attempting an "all-at-once" rollout, spread is best achieved in waves or sequential cycles:

- Start with high-readiness clinics (innovators and early adopters).
- Refine processes and tools with this first wave.
- Expand to the early majority once momentum and peer learning take hold.
- Plan for later waves to reach the late majority and late adopters.

This approach reduces risk, allows rapid learning, and builds credibility by showing quick wins before scaling across the full network.

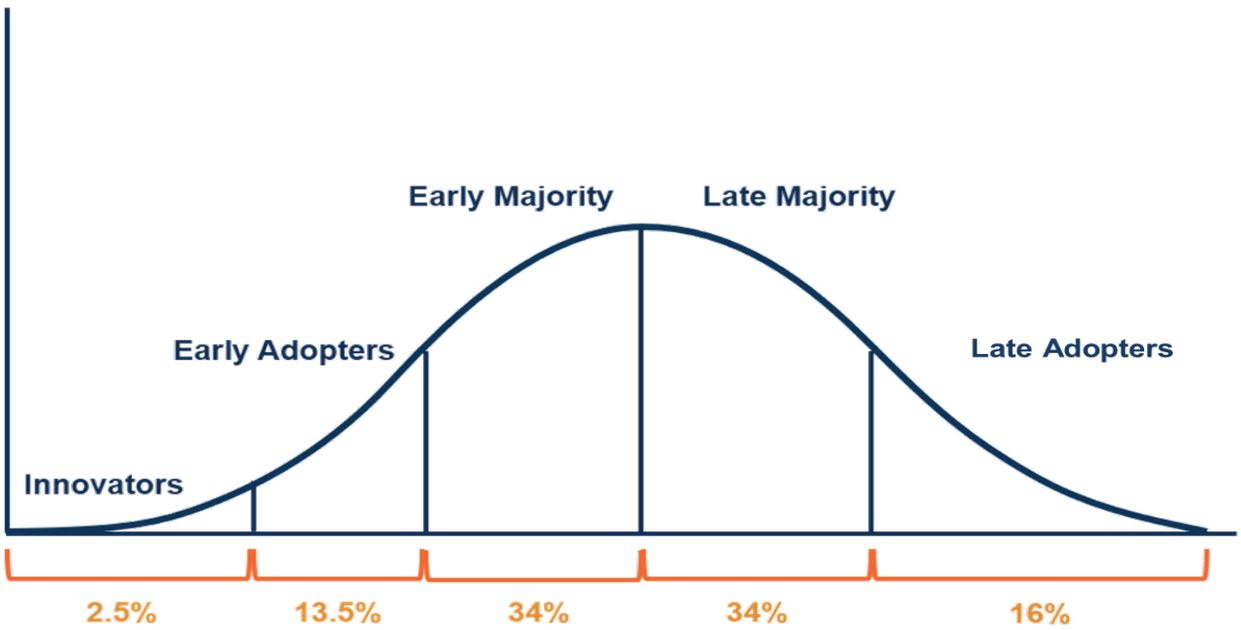
Rogers' Diffusion of Innovation Curve

A framework that explains how innovations are adopted over time:

- Innovators (2.5%) – first to test new ideas.
- Early Adopters (13.5%) – quick to adopt and influence others.
- Early Majority (34%) – adopt once evidence is clear.
- Late Majority (34%) – adopt after widespread uptake.
- Late Adopters (16%) – last to adopt.

This guide prioritises spread to Early Adopters and Early Majority (50% of clinics) to build momentum.

Everett Roger's Diffusion of Innovation Theory



Source: Rogers, E. M. (2003). *Diffusion of Innovations*

Early Adopters

Clinics or providers willing to try and champion new practices. Their success stories and influence are crucial in motivating peers.

Early Majorities

Clinics or providers who are more cautious than early adopters but become engaged once they see evidence of success from their peers. They are pragmatic, preferring proven solutions over untested ones, and often look for reassurance through data and peer endorsements. Their participation is critical for building momentum, as together with early adopters they make up nearly half of the adoption curve. Once engaged, the early majority helps normalise new practices and shift improvements into routine care.

* Identifying Early Adopters and Early Majority clinics goes beyond just looking at numbers. It is about readiness, willingness, and influence.

Here is a set of guiding questions you can use during selection discussions or readiness assessments:

Early Adopters: These clinics are usually the ones eager to try new things and can champion spread.			
Leadership & Motivation	**Culture & Openness to Change**	**Influence & Role Modelling**	**Capacity & Readiness**
• Does clinic leadership show strong interest in testing and adopting new processes? • Have they previously volunteered for pilots or QI projects?	• How does the clinic typically respond to new initiatives with enthusiasm, neutrality, or resistance? • Do staff view improvement work as an opportunity or a burden?	• Does this clinic have a reputation for being innovative or influential within the PCN? • Could they act as a role model or "proof point" for others?	• Do they have a champion (doctor, nurse, or coordinator) willing to lead the change? • Do they have enough baseline resources (staff, IT, workflows) to implement without overwhelming strain?
Early Majorities: These clinics are more pragmatic — they adopt once they see evidence and peers succeeding.			
Trust in Evidence	**Peer Influence**	**Risk Appetite**	**Practical Constraints**
• Would this clinic adopt it once early adopters show success and data? • Are they motivated by seeing local results rather than national directives?	• Are they influenced by stories or endorsements from clinics they respect? • Do they look for reassurance that processes have already been refined?	• Are they cautious about being first but open to joining once risks are lower? • Do they tend to follow rather than lead?	• Do they face barriers (staff turnover, workflow challenges) that make them less suited as first movers but manageable once templates and support are available?

Contextualisation

The process of adapting a standardised improvement (e.g., diabetic foot & eye screening and vaccination workflow) to fit a clinic's local circumstances while maintaining fidelity to the core components.

Sustainability

The ability of improvement to be maintained as part of routine practice long after initial project support has ended. Sustainability requires embedding processes into workflows, measurement systems, and incentives.

Core Framework & Steps

To ensure a shared understanding across the Primary Care Network (PCN), this section defines the key concepts that underpin the guide.

Step 1: Identify Early Adopters and Set Feasible Targets

1.1 Apply Rogers' Diffusion Curve:

- Map clinics along the adoption spectrum.
- Focus initial spread efforts on early adopters and the early majority (50% of clinics).

1.2 Define Selection Criteria:

- Diabetic Foot & Eye Screening (DFS/DRP): Clinics with type 2 DM–diagnosed HSG enrollees requiring improvement in annual screening rates.
- Vaccination: Clinics with high patient volume ≥65 years old and requiring improvement in vaccination rates.

1.3 Conduct Stakeholder Analysis:

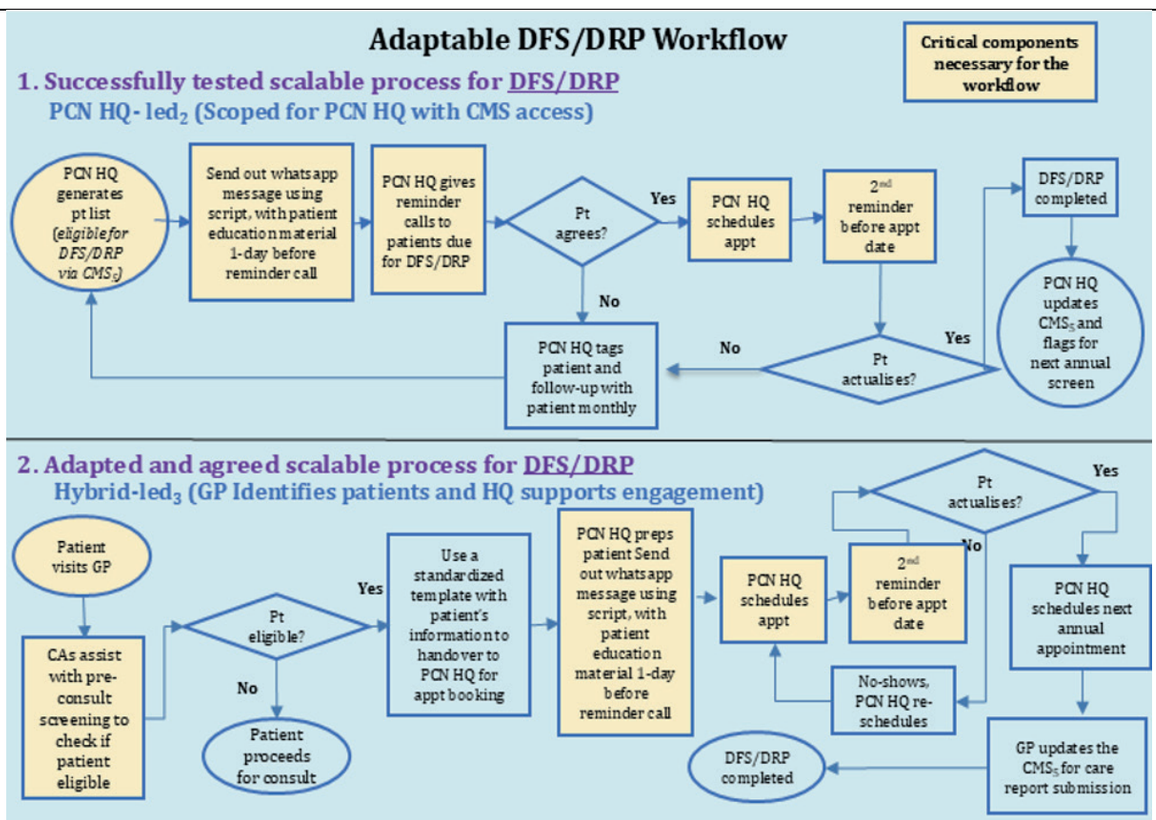
- Map clinics and their key influencers (doctors, nurses, and care coordinators).
- Assess readiness, motivations, and barriers.

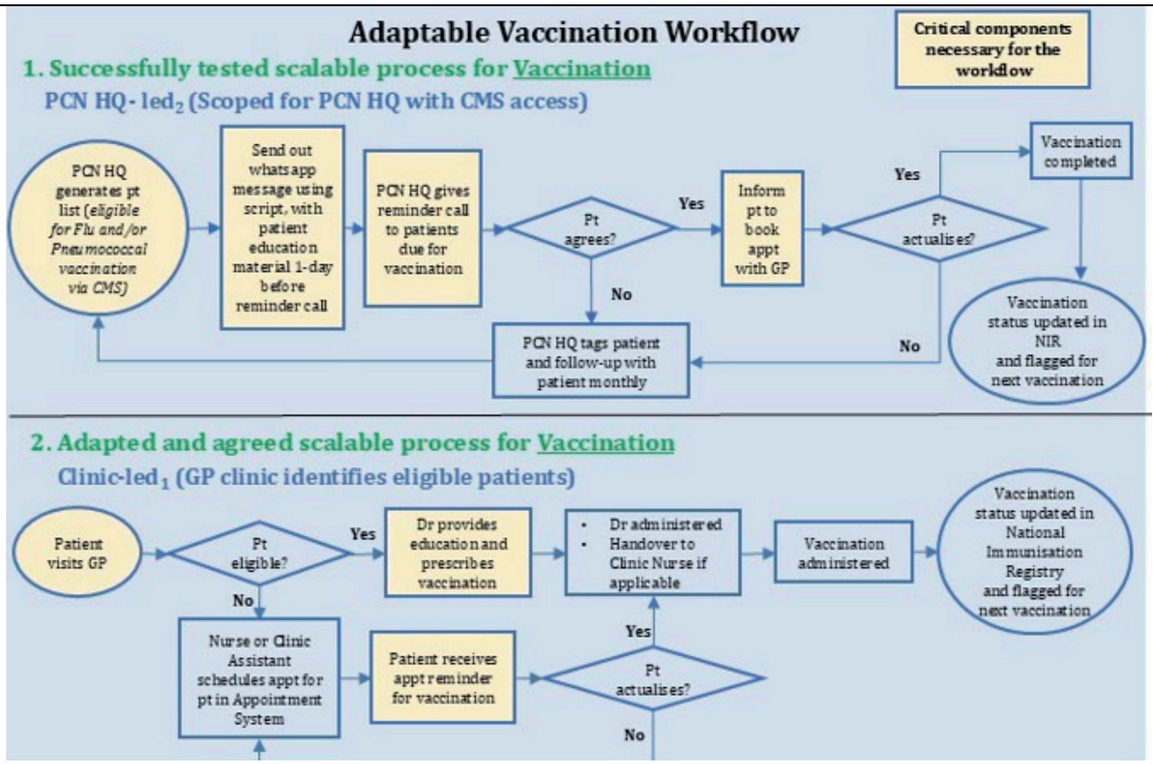
1.4 Set Feasible Aims and Targets:

Scalable Process	Adoption Measure	Outcome Measure
DFS/DRP	Spread scalable processes to 50% of clinics by Mar 2026	Improve screening rates by 20%.
Vaccination	Spread scalable processes to 50% of clinics by Mar 2026	Improve screening rates by 20%.

Step 2: Develop a Spread Plan

2.1 Define Scalable Processes:

Scalable Process: DFS/DRP	
Core Components	– Identifying eligible patients – Proactive engagement of eligible patients with standardized patient education – Appointment booking – 2nd reminder before appointment date
Process Map	

Scalable Process: Vaccination	
Core Components	– Identifying eligible patients – Proactive engagement of eligible patients with standardized patient education – Appointment booking
Process Map	

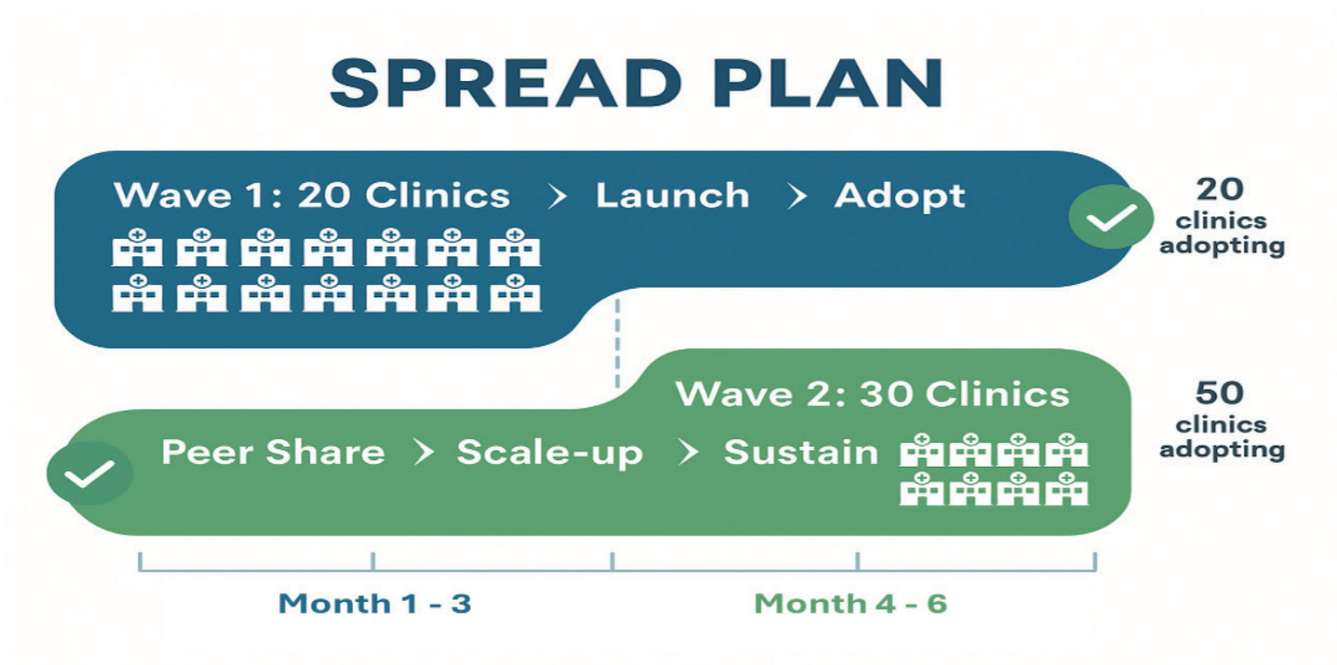
2.2 Implementation Timeline:

- Month 1: Engage early adopters, test workflows, and refine.
- Month 2–3: Spread to early adopters.
- Month 2-3: Consolidate learning, prepare for sharing with early majorities.
- Month 4-6: Spread to early majorities.
- Month 7+: Consolidate learning, prepare for later majority/adopters.

2.3 Roles and Resources:

- Assign PCN Spread Team Leads for DFS/DRP and Vaccination.
- Identify clinic champions for peer-to-peer influence.
- Provide a quick implementation guide and materials.

Sample Visual Mapping:



Sample Gantt chart:

Month	Wave 1 (20 Clinics)	Wave 2 (30 Clinics)
Month 1	Launch	
Month 2	Adapt & Adopt	
Month 3	Adopt & Review	
Month 4		Peer Sharing
Month 5		Scale-up
Month 6		Sustain & Review
All 50 Clinics identified (Early Adopters & Early Majorities) adopted		

Step 3: Build a Communication Plan

3.1 Key Messaging:

- Highlight patient benefits (early detection, reduced hospitalisations).
- Emphasise alignment with PCN and national goals.
- WhatsApp/instant messaging: real-time support.
- One-on-one engagement: direct troubleshooting with clinic leads.

3.2 Communication Channels:

- Newsletters: monthly updates with data and spotlights.
- PCN meetings: progress reviews and peer learning.
- Share success stories and data from early adopters.

Audience	Message / Purpose	Channel	Frequency	Owner	Notes
Clinic Leaders (Wave 1 & 2)	Why this process matters, expectations for adoption, milestones	Email + Kick-off Meeting	Before launch, then monthly	Spread Lead	Highlight alignment with PCN priorities
Clinic Champions	Practical tools, success stories, data dashboards, peer learning	WhatsApp group / MS Teams + Monthly huddles	Weekly updates + Monthly call	QI Coach	Champions amplify messages inside clinics
Frontline Staff (nurses, admin)	Step-by-step workflow guidance, patient messaging, quick wins	Posters, one-pagers, short training	At start + as needed	Clinic Champion	Keep messages short and visual
Patients / Public	Benefits (better screening, easier access to vaccines)	Leaflets, SMS/Whatsapp reminders, posters in clinic	Ongoing	Clinic Team	Patient voice helps drive uptake
PCN Leadership / Executives	Progress updates, adoption rates, ROI, barriers	Dashboard report + Quarterly briefing	Monthly dashboard, quarterly deep dive	Spread Lead + HQ Ops	Use data + stories together
Peer Clinics (Wave 2)	Lessons learned from Wave 1, reassurance, motivation	Learning sessions, peer-to-peer calls	Midpoint Wave 1, pre-Wave 2	Early Adopter Clinics	Peer influence is key for early majority
Wider System / External Stakeholders	Showcase outcomes, equity impact, scalability	Reports, newsletters, conferences	Quarterly / at milestones	PCN Leadership	Builds momentum and credibility

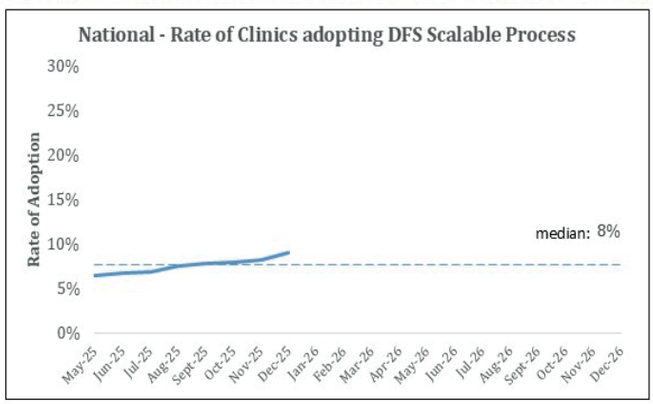
Step 4: Monitoring, Feedback, and Review

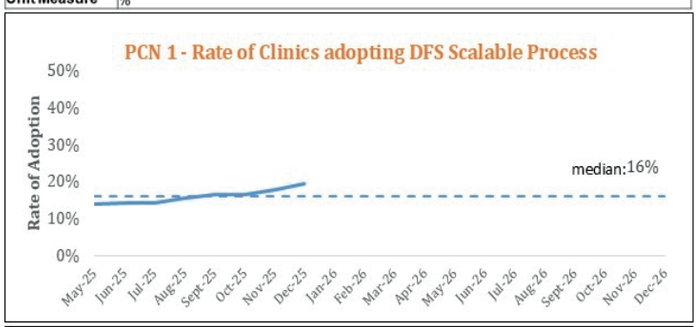
4.1 Monitoring: (Dashboard mock-up from NIU)

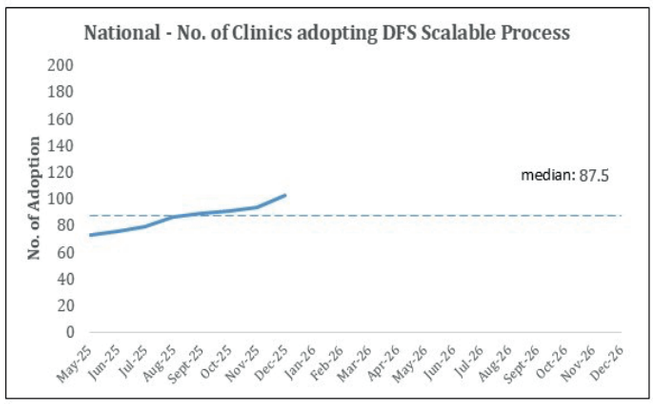
- Track adoption status and performance against timelines.
- Use dashboards -provided by NIU.

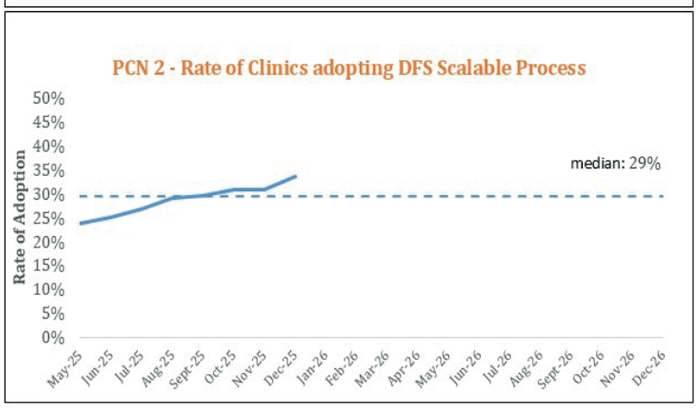
Adoption Measure Dashboard (mock-up):

Indicator	Rate of Clinics adopting DFS Scalable Process
Measure Type	Outcome
Numerator	Number of clinics from the denominator group who adopted the DFS Change Package
Exclusion	NA
Denominator	Number of clinics in the PCN
Exclusion	NA
Unit Measure	%



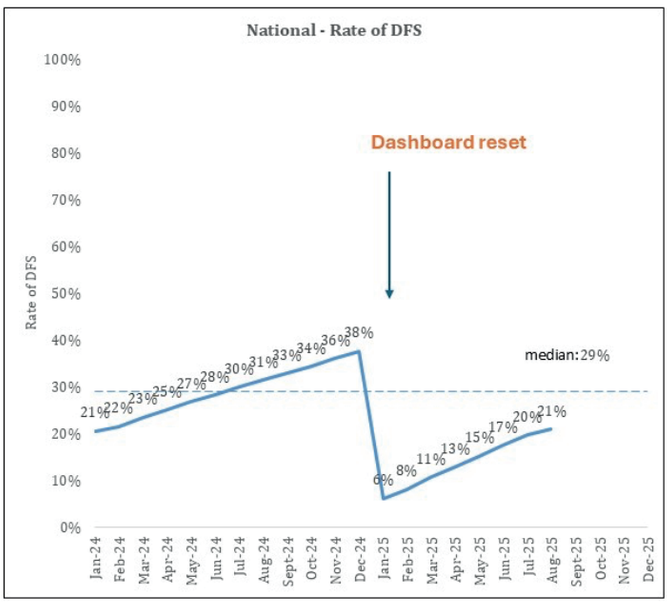


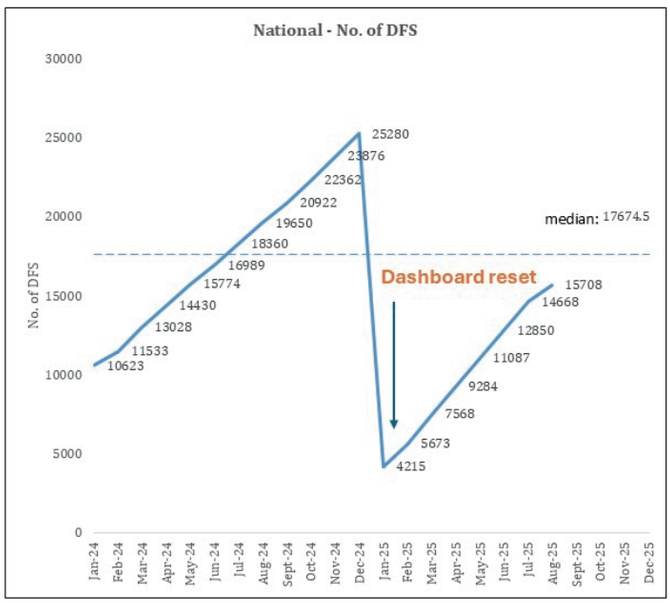




Outcome Measure Dashboard: (mock-up)

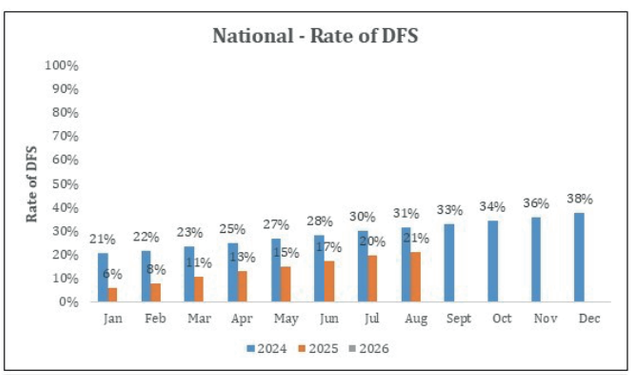
Indicator	Change in DFS Rate
Measure Type	Outcome
Numerator	Change in Rate of DFS between current month and previous month
Exclusion	NA
Denominator	NA
Exclusion	NA
Unit Measure	%

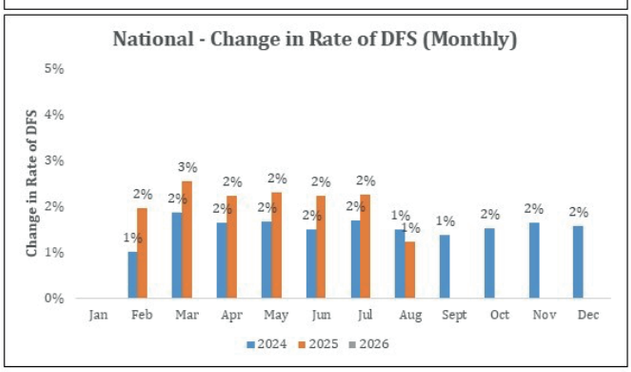


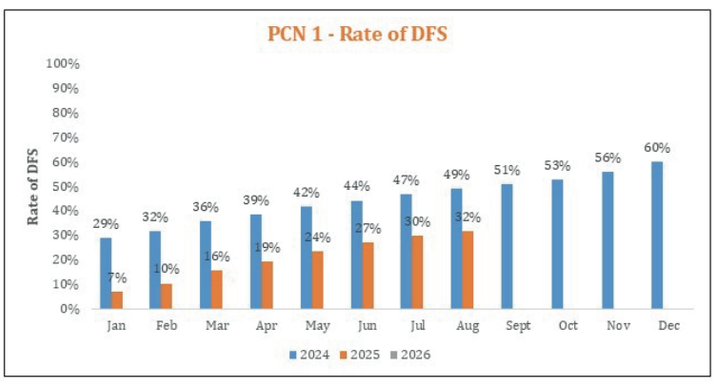


Outcome Measure Dashboard (mock-up):

Indicator	Change in DFS Rate
Measure Type	Outcome
Numerator	Change in Rate of DFS between current month and previous month
Exclusion	NA
Denominator	NA
Exclusion	NA
Unit Measure	%







4.2 Support Mechanisms:

- Check-ins: weekly/fortnightly in month one, monthly thereafter.
- Spread Team can book for consult sessions with NIU.

4.3 Feedback & Continuous Improvement:

- Capture feedback at check-ins and meetings.
- Document barriers and share solutions.

4.4 Mid-Review:

- Assess spread targets.
- Identify gaps and corrective actions.
- Celebrate progress and highlight high performers to share their ingredients for success.
- Mid-Review Network Learning – Group Call Sharing Session across PCNs facilitated by NIU.

Enabling Structures

Governance & Accountability

- PCN Leadership Oversight: The Steering committee is accountable for spread outcomes.
- Clinic-Level Accountability: Appoint Clinic Champions.
- Escalation Pathway: Define resolution processes.

Capacity Building & Training

- Training modules: standardised content.
- Hands-on workshops: early adopters can role-model workflows.
- Onboarding tools for new staff.

Data & Measurement Framework

Scalable Process	Adoption Measure	Outcome Measure	Data Source
DFS/DRP	Spread scalable processes to 50% of clinics by Mar 2026	Improve screening rates by 20%.	• Quality Indicator Dashboard (QID) for outcome measures • Adoption measure to be provided by PCN HQ (Spread Team) – 5th of every month • NIU will provide monthly Progress Report on Measures – 15th of every month
Vaccination	Spread scalable processes to 50% of clinics by Mar 2026	Improve screening rates by 20%.	

Incentives & Recognition

- Certificates, newsletters, meeting spotlights.
- Link improvements to quality indicators.

Risk Management & Barrier Mitigation

Barrier	Mitigation Strategy
Workload concerns	Streamlined workflows, CMS integration
Staff turnover	Standardised onboarding and training
Patient hesitancy	Counselling scripts, multilingual materials
Resource constraints	Phased onboarding, PCN support

Sustainability & Future Scale

Governance & Accountability

- Plan for spread to the late majority and late adopters.
- Use peer-to-peer learning with clinic champions mentoring others.
- Embed processes into PCN operations and audits.
- Continue communication and recognition beyond project timelines.

Conclusion

This guide provides a comprehensive pathway to spread and scale diabetic foot & eye screening and vaccination across PCN GP clinics. By engaging early adopters, setting clear targets, building communication strategies, and embedding robust governance, training, and monitoring systems, PCNs can achieve measurable improvements in preventive care outcomes.

With consistent application, PCNs will be able to:

- Achieve 50% clinic adoption by target dates for DFS/DRP and Vaccination.
- Improve patient screening and vaccination rates by 20% in participating clinics.

The ultimate goal is not only adoption but sustainability, ensuring these preventive practices become embedded in everyday primary care operations, benefiting patients for years to come.

Annex:

Clinic Selection Matrix

Purpose: To compare clinics side by side and rank them based on *need*, *readiness*, and *impact potential*.
Scoring: Use 1 (low), 2 (medium), or 3 (high) for each domain. Total possible score = 15.

Interpreting the Score:

- Higher total score = higher priority
  - These clinics are both ready and impactful (high performance gaps, leadership buy-in, equity need).
  - They are your best candidates for early waves of spread.
- Medium scores = moderate priority
  - These clinics may need targeted support to succeed.
  - They can form your second wave.
- Low scores = lower priority
  - Either not ready or lower impact.
  - Better to defer until later (or build capacity first).

Clinic	Current Performance Gap (foot, eye, vax)	Readiness & Leadership Commitment	Capacity & Resources	Equity / Population Need	Overall Priority Score
Clinic A	3 (very low screening & vax rates)	2 (leadership interested but limited time)	2 (staffing stable, IT limited)	3 (serves high-need, underserved population)	10
Clinic B	2 (moderate gaps)	3 (strong director champion & team engaged)	3 (good staff, IT, space)	2 (mixed population)	10
Clinic C	1 (rates close to target already)	2 (moderate engagement)	2 (capacity fair)	1 (lower-need population)	6
Clinic D	3 (large gap in vax uptake)	3 (strong leader + QI experience)	3 (ample resources, retinal camera onsite)	3 (high disparities in population served)	12

Clinic Selection Matrix Tool

Clinic	Current Performance Gap	Readiness & Leadership Commitment	Capacity & Resources	Equity / Population Need	Overall Priority Score

Clinic Assessment Checklist

*Helps identify readiness and classify clinics as **Early Adopters** or **Early Majorities***

1. Leadership & Motivation

☐ Clinic leadership actively **volunteers** for pilots or improvement initiatives.

☐ Leaders express **strong commitment** to scaling preventive care (screening, vaccination).

☐ Past track record: has the clinic successfully implemented QI projects before?

2. Culture & Attitude Toward Change

☐ Staff are generally **positive** about trying new workflows or processes.

☐ The clinic views QI as an **opportunity** rather than a burden.

☐ New initiatives are usually adopted **early** in this clinic compared to peers.

3. Champions & Capacity

☐ The clinic has an **identified champion** (doctor, nurse, coordinator) willing to lead spread.

☐ Staff capacity and resources are **adequate** to trial new processes without overwhelming strain.

☐ Clinic uses data or dashboards regularly to guide practice.

4. Influence & Peer Role

☐ This clinic is regarded as an **influencer** or role model by other PCN clinics.

☐ The clinic is open to **sharing learning** with others (peer teaching, presentations).

☐ The clinic has previously acted as a **mentor site**.

5. Adoption Style (Self-Assessment or Observation)

☐ **Eager first movers** → Early Adopter

☐ **Willing once success is shown elsewhere** → Early Majority

☐ **Cautious, slow to adopt** → Later waves

Scoring & Classification

- **Mostly YES in Sections 1–4 → Early Adopter** (high readiness, can lead the first wave).
- **Mixed YES in Sections 2–3, cautious in Section 5 → Early Majority** (good for the second wave once evidence is shown).
- **Mostly NO** → Lower readiness, defer to later waves.

Spread Plan Checklist

*Helps identify readiness and classify clinics as **Early Adopters** or **Early Majorities***

1. Define the Aim

☐ Identify the scalable process (tested & proven).

☐ Write a clear aim statement with measurable goals.

☐ Confirm alignment with system or PCN priorities.

2. Select Target Clinics

☐ Use the Clinic Selection Matrix to score clinics.

☐ Prioritise early adopters for Wave 1.

☐ Assign waves (Wave 1 = early adopters; Wave 2 = early majority).

3. Build the Timeline

☐ Decide the length of each wave (e.g., Wave 1 → 3 months, Wave 2 → 6 months).

☐ Set milestones (communication strategy complete, training complete, adoption tested, spread achieved).

☐ Schedule regular review points (weekly for the 1st month, monthly check-ins).

4. Assign Roles

☐ Spread Lead (PCN HQ Manager).

☐ Clinic Champion (per site).

☐ QI Coach / Facilitator (PCN QI Leads, Cluster QI support).

☐ Data Ops personnel.

5. Enable Success

☐ Prepare training & coaching sessions.

☐ Provide data dashboards for progress.

☐ Supply patient education & workflow tools.

☐ Plan incentives / recognition.

6. Monitor & Adapt

☐ Define KPIs.

☐ Agree on reporting platform and frequency (monthly/quarterly PCN meeting).

☐ Capture lessons from Wave 1.

☐ Refine for Wave 2 and beyond.

Communication Plan *(Example)*

Audience	Message / Purpose	Channel	Frequency	Owner	Notes
Clinic Leaders (Wave 1 & 2)	Why this process matters, expectations for adoption, milestones	Email + Kick-off Meeting	Before launch, then monthly	Spread Lead	Highlight alignment with PCN priorities
Clinic Champions	Practical tools, success stories, data dashboards, peer learning	WhatsApp group / MS Teams + Monthly huddles	Weekly updates + Monthly call	QI Coach	Champions amplify messages inside clinics
Frontline Staff (nurses, admin)	Step-by-step workflow guidance, patient messaging, quick wins	Posters, one-pagers, short training	At start + as needed	Clinic Champion	Keep messages short and visual
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Peer Clinics (Wave 2)	Lessons learned from Wave 1, reassurance, motivation	Learning sessions, peer-to-peer calls	Midpoint Wave 1, pre-Wave 2	Early Adopter Clinics	Peer influence is key for early majority
Wider System / External Stakeholders	Showcase outcomes, equity impact, scalability	Reports, newsletters, conferences	Quarterly / at milestones	PCN Leadership	Builds momentum and credibility

📣 Communication Plan Tool

Audience	Message / Purpose	Channel	Frequency	Owner	Notes

Spread and Scale Framework (Action Lab)

Action lab is designed to support teams in actively adopting and implementing tested change ideas that have demonstrated success in similar contexts. It provides a structured, hands-on environment to assess readiness, adapt solutions, and create actionable plans for spreading and scaling improvements.

Jul'25	Aug'25 [pre-work]	27 Sep'25 [Launch Action Lab]		Oct'25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
		Week 1 and 2	Week 3 and 4	Week 1 to Week 4					
• Send out customized email to invite PCNs for Action Lab • Bring together team leads/PCN ops of similar projects to curate and co-design for next level of improvement	• Engagement with Teams • Baseline for **10%** of participating clinics [Jan 2025 to Jun 2025] • Adapted process • Develop spread plan • Identify clinics for spread	• Implement adapted process to **10%** of the clinics • Contextualise process • Start tracking weekly data	• Continue tracking weekly data • Comms to next 20% of clinics for adoption	• Spread to the **20%** of clinics	• Spread to next **70%** of clinics sequentially • Track outcome measures (Uptake of indicator and Adoption)				

Aim/Target:

Adoption Measures

1. By 31 Mar 2026, 50% of clinics in the PCN Xxx will adopt the new ***DRP/DFS process***.
2. By 31 Mar 2026, 50% of clinics in the PCN Xxx will adopt the new ***Vaccination process***.

Clinical Outcome Measures

1. To improve percentage mean of ***Diabetic Foot and Eye Screen*** by 20% in X number of participating clinics (PCN Xxx) by 31 Mar 2026.
2. To improve percentage mean of ***Influenza and Pneumococcal Vaccination*** by 20% in X number of participating clinics (PCN Xxx) by 31 Mar 2026.

DFS/DRP & Vaccination Action Lab Milestone & Timeline