

Supporting sustainable change

Breast Services Enhancement Program

Learning from the past—informing the future

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Preface

Welcome to *Learning from the past—informing the future*, the learning series based on the experiences of the Victorian Breast Services Enhancement Program.

The Breast Services Enhancement Program commenced in 1999 as a key component of the Breast Disease Service Redevelopment Strategy 1999–2003¹ (BreastCare Victoria).

Since the implementation of BreastCare Victoria and the Breast Services Enhancement Program, there has been an increasing national and state focus on improving services for all people with cancer. As with breast cancer, in addition to improving discrete health outcomes such as survival and morbidity through evidence-based best practice, there is increasing emphasis on improving the experiences of people with cancer as they navigate our complex health system.²

These two aspects, improving clinical outcomes and the consumer experience, were the focus of the service redevelopment and quality improvement initiatives of the Breast Services Enhancement Program.

From 1999 to mid 2004, nine consortia of health services across Victoria joined to develop and implement the Breast Services Enhancement Program. Over sixty different initiatives of various sizes were implemented. The presence of the Breast Services Enhancement Program also enabled us to seize other unexpected opportunities to help achieve our goals.

This learning series provides examples of the many experiences of the Breast Services Enhancement Program—key learnings, critical success factors and challenges. We learned what worked well, what worked less well, what made the difference and what we could do differently next time.

The learning series addresses these topics:

- multidisciplinary care—improving consumer outcomes
- continuity and coordination of care—improving the ‘cancer journey’
- supporting sustainable change
- building partnerships with consumers for improved service delivery.

The learning series reflects the hard work of all program staff, clinicians, breast care nurses, consumers and other health and community workers, as well as members of the BreastCare Victoria Advisory Committee. We thank you all for your significant contributions, enthusiasm and commitment.

Each resource in this learning series draws on evidence from the statewide evaluation of the Breast Services Enhancement Program and on individual evaluation reports. Evidence has also been gleaned from further discussions with key stakeholders in the field.

While each resource stands alone, links are made with other documents in the series along with other useful references, resources and tools.

We hope that the experiences and learnings of the Breast Services Enhancement Program may be of assistance to you in your work, whether it is in achieving new initiatives within cancer reform or in other health care reform.

A handwritten signature in black ink, appearing to read 'Lyn Swinburne'. The signature is fluid and cursive, with a large initial 'L' and 'S'.

Lyn Swinburne
Chair, BreastCare Victoria Advisory Committee (1999–2004)

Acknowledgements

This learning series was written by Sheila Hirst on behalf of Cancer and Palliative Care, Victorian Department of Human Services. We thank those stakeholders who provided additional local knowledge and experiences to inform this series.

The learning series *Learning from the past—informing the future* is based on the experiences of the following nine Victorian consortia who participated in the Breast Services Enhancement Program 1999–2004.

Metropolitan consortia

Western	Royal Melbourne Hospital, Royal Women’s Hospital, Western Health and associated private providers
North Eastern	Austin Health, Northern Hospital, Peter MacCallum Cancer Centre, St Vincent’s Health
Southern	Dandenong Hospital, Monash Medical Centre.
Inner and Eastern	The Alfred, Eastern Health (Box Hill, Maroondah and Angliss Hospitals), Peter MacCallum Cancer Centre, and associated private providers

Regional consortia

Barwon–South Western Region

Grampians Region

Loddon Mallee Region

Hume Region

Gippsland Region

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Given that it is likely that nothing works all the time, and that everything works some of the time, there is a need to explore not only what seems to work, but also why it might be expected to work in what circumstances.

Nutley and Davies 2000³

Years of study and experience show that the things that sustain change are not the bold strokes but the long marches—the independent, discretionary and ongoing efforts of people throughout the organisation.

Moss Kanter 1999⁴

The process was totally new to me. It was a real learning experience. If you get enough people together, not in an antagonistic way, but in an optimistic way and say 'what can we do and what needs improvement?' It works and then it sort of feeds on itself.

Clinical Coordinator, Breast Services Enhancement Program⁵

Summary of learnings

Evidence from the literature

- Organisational change is a complex, multilayered and non-linear process. Many complex interacting factors influence the uptake of change and are contingent on the organisational context. There is no one recipe for change.
- Successful organisational change facilitates the uptake of an innovation or improved practice and the capacity of the organisation to take up further change in the future.
- In some circumstances, change at an individual or service level may only occur if there are corresponding changes at a broader system level.
- Incremental change, with strong local ownership and clarity of purpose, is more likely to result in sustainable change.
- Leadership, a supportive environment, time and resources all contribute to achieving organisational change.

Learnings from the Breast Services Enhancement Program

- The Program's learnings are in synergy with the evidence from the literature.
- Improving the uptake of evidence-based guidelines requires innovative processes to achieve changes in clinical practice, enhanced collaboration between disciplines, and changes in the organisation of care. It also requires changes in mindsets and organisational culture.
- Effective local leadership, together with Program staff who act as change agents, are crucial to achieve change. Effective leadership is needed to champion change and can be found in organisational roles, designated clinical coordinators or other opinion leaders, such as managers and heads of units.
- Program staff need to:
 - have or develop a wide range of skills in organisational change
 - establish their legitimacy and credibility with stakeholders
 - draw on personal authority
 - work in partnership with all stakeholders
 - manage contradictions
 - build linkages between stakeholders.
- To optimise organisational change within the health sector, a balance is needed between a top-down and bottom-up approach. A strong bottom-up and incremental approach facilitates local ownership. A top-down supportive leadership approach, which uses levers judiciously, can create a sense of urgency and legitimacy to facilitate the required change.
- Developing and maintaining consortia of services for health care reform needs to accommodate the different organisational interests and cultures. Once well established, the consortia can facilitate the spread of innovations.
- Collaborative relationships are facilitated as mutual trust develops, and as an outcome of stakeholders working together with a clear purpose and task.

- Evaluating change is complex and requires significant resources and skills to capture both clear outcomes and subtle shifts in practice or mindsets.
- Sustainability of change depends on demonstrated benefit and early embedding of functions or roles into organisational norms, structures and funding mechanisms.
- The sustainability of some initiatives is problematical and requires ongoing dialogue between local and departmental stakeholders. The single focus on breast cancer limits the ability to incorporate initiatives into current or new funding mechanisms based on broader funding models.
- Further consideration is needed in how to maintain interest and momentum in sustaining change, rather than the continuing drive for the next innovation.

Case study 1

Introducing early psychosocial assessment into breast care nurse practice

Where we started

Within one Breast Services Enhancement Program (BSEP) there was a strong network of experienced breast care nurses (BCNs). Following an initial project, the BSEP staff and BCNs identified the need and an opportunity to strengthen the formal psychosocial assessment process for women and men with breast cancer.

What was changed?

A core group of five BCNs worked with staff to develop a psychosocial risk assessment and screening approach based on the evidence-based guidelines. Four BCNs from two other BSEPs then joined the team to trial the approach. There was strong local ownership with each BCN supported to submit the trial to their local ethics committee. Clinical stakeholders were strongly supportive of the initiative.

Following a training program, some BCNs readily adopted the approach, whereas others needed more encouragement and support to do so. Over eight months nine BCNs recruited a total of 115 people (113 women and two men) to participate in the trial.

Trial participants found the assessment process highly acceptable. BCNs reported increased confidence in their assessment and referral skills and their capacity and credibility as members of the multidisciplinary team.

What was sustained?

After the trial, eight out of the nine nurses had successfully integrated the approach into their routine practice. Several developed additional processes to assist their team's response to women's needs.

What was spread?

The approach was adopted with some modifications to support a separate BCN initiative within another BSEP. The education program and other support mechanisms were also modified in response to local issues. The nurses who provided care across the continuum adopted the approach more readily than those who only saw women and men during the perioperative period.

Critical success factors for change

- ✓ Local ownership.
- ✓ Peer and program support.
- ✓ Key executive and clinical stakeholder support.
- ✓ Benefits for women and men with breast cancer.
- ✓ BCNs perceived benefit for practice.
- ✓ Sustained over time and spread to other services.
- ✓ Uptake and sustainability varied according to local contexts.

1 Introduction

Supporting sustainable change is the final resource in the learning series based on the experiences of the Victorian Breast Services Enhancement Program (the Program).

Improving outcomes for women with breast cancer and other breast conditions was the clear driver for the Program. Achieving this meant organisational change—change that focused not just on improving the individual skill level, but importantly on the skills and capacity of the team, service and systems level.

It also meant that if improvements or innovations were to be effective, the change needed to be sustained over time within that setting, as well as being adopted by others. In this way, the change becomes ongoing and does not just stay in ‘small pockets of improvement’; rather, the learning and the underlying principles of the initiative are adopted by others and become the practice norm.⁶

An understanding of organisational change is needed, whether trialling an innovation or practice change for the first time, trying to sustain it or encouraging others to adopt it. While multiple theories and approaches to achieving sustainable change abound, it is clear that no one recipe meets all needs. Instead, change is seen to depend on a large number of factors operating at different phases and different levels within any one organisation and in different combinations to influence performance.⁷

This resource captures the experiences of the Program and articulates some of the challenges we faced and our learnings.

The next section examines the context in which the Program developed. Section 3 considers the evidence from the literature on organisational change, Section 4 introduces the Program learnings and Section 5 articulates the key learnings.

Section 6 provides more detailed evidence on which the findings are based, and Section 7 considers issues of measuring and sustaining change.

Section 8 provides information on a range of resources and tools that may be useful to other services as they embark on future health service reform and improvement programs.

Throughout the text these following symbols are used:

- ★ denotes **benefits** or outcomes of service improvement
- ✓ denotes **critical success factors** of service improvement
- ◇ denotes **challenges** to service improvement

2 Supporting sustainable change –the context

During the 1990s the need to improve the breast care service system for women and their families was increasingly recognised nationally and at a state level. Within Victoria, this recognition culminated in the development of the Breast Disease Service Redevelopment Strategy,¹ of which the Breast Services Enhancement Program was a part.

The Strategy emphasised developing collaborative relationships between services and service providers through the establishment of nine consortia of service providers to implement the Program across Victoria. These consortia were based on the then metropolitan health care networks and the Department of Human Services' rural regions. However, the underlying culture at the time was also influenced by the broader political environment, which emphasised the 'forces of the marketplace'. This was reflected in a strong purchaser-provider split and the encouragement of competition rather than collaboration.⁸

The metropolitan health care networks and the department's rural regions did not always represent natural alliances of services, and uneasy relationships existed at times between different providers. In addition, other departmental quality improvement initiatives (such as the maternity services enhancement program and discharge planning initiatives) tended to be service specific, rather than focused on working across networks or alliances. In many ways, the 1999 development of the Program consortia set a precedent.

Overall service providers embraced the Program's establishment and endorsed the broad parameters for service improvement. The Program had a strong developmental 'bottom-up' approach to achieve incremental service improvement. There was an understanding that once trialled, successful initiatives would be embedded into 'normal' practice at local sites and opportunities exploited to ensure their uptake by other services.

Over the Program's life, we learned about what worked in some settings, what worked less well in others and the factors that made the difference. Some factors can be clearly articulated, whereas others resulted from a more intuitive understanding of the system and by being alert to potential opportunities and problems.³ It was often the combination of all these factors that created the levers for change and facilitated our understanding and learnings about organisational change in complex settings.

This complexity of organisational change is reflected in the literature, which is reviewed in the next section. We will then discuss the experiences of the Breast Services Enhancement Program.

3 What the evidence tells us

Key messages

- Organisational change is a complex, multilayered, non-linear process.
- Whether introducing change for the first time, sustaining it or encouraging its adoption by others, similar approaches are required.
- In some circumstances, change in practice at an individual or service level can only occur if there are corresponding changes at a broader systems level.
- Change is more difficult when it requires complex changes in clinical practice, collaboration between disciplines and changes in the organisation of care.
- In health care, a number of tensions and contradictions occur, which need to be managed in organisational change.
- A balance is needed between top-down and bottom-up approaches to organisational change.
- Leadership, creating a supportive environment, time and resources are all critical to achieve organisational change.
- There is increasing literature that can inform the effective implementation of innovations in the delivery of health care services.

The development and general dissemination of evidence-based guidelines,^{9, 10, 11} have gone some way toward supporting best practice service delivery in the management of Australian women with breast cancer. However, as with other health care research, the passive dissemination of research evidence has a limited impact. The evidence about the best ways in which clinical practice guidelines can be effectively integrated into routine clinical practice and service delivery is also limited.¹²

Many obstacles have been identified in bridging the gap between the evidence and what patients receive.¹³ The ‘big bang’, or revolutionary approach to organisational change, is increasingly seen as ineffective in bridging this gap and in sustaining change. This approach has been replaced by more incremental or evolutionary approaches, in which organisational groups or teams gradually cultivate the required new mindset and practice changes.¹⁴

While there are many approaches to supporting sustainable organisational change,¹⁵ it is clearly not a linear process; in reality, supporting and sustaining change is a messy and unpredictable journey.³ Untangling the ‘mess’ provides guidance for future journeys.

In the following discussion consideration is given to the underlying concepts of developing and sustaining innovation and change. Those factors that influence the successful uptake of innovation or change strategies are then reviewed.

3.1 Key concepts and definitions

3.1.1 Innovation, change and organisational learning

Within the health system, the purpose of any organisational change is to bring about new ways of thinking and working¹⁶ that will improve outcomes for patients and the system.

However, the uptake of any innovation may require significant change to overcome individual and organisational barriers, and necessitates an understanding of how the concepts of improvement, change and learning are deeply intertwined.¹⁷

At one level, service improvement may achieve ‘doing what we do better’ within current systems. This is called ‘first-order change’ or ‘single-loop learning’. To achieve other changes the organisation and the individuals within it may be challenged to make fundamental changes to the organisational culture and to rethink goals, norms and ways of thinking. This is called ‘second-order change’ or ‘double-loop learning’.^{18, 19}

Box 1 provides simple examples of single and double-loop learning.

Box 1: Single loop and double loop learning

Example 1: Changing medications

A change from prescribing medication A to medication B requires providers to have knowledge and understanding of the benefits of the new medication. It does not require them to work in a different way. This is called first-order change or single-loop learning.

Example 2: Introducing evidence-based guidelines

To introduce evidence-based guidelines to improve multidisciplinary care may require the development of stronger teams with new, formal communication mechanisms. This may change the fundamental way services and providers practice. It requires second-order change or double-loop learning.

Organisational change aims to achieve the adoption of a service improvement and strengthen the organisation’s capacity for change.

Any organisational change has a dual purpose:

- to achieve the uptake of the innovation
- to strengthen the capacity of the organisation and the individuals within it to respond, manage and initiate change in the future.^{3, 20}

3.1.2 Sustainability

Change sticks when it becomes the way we do things around here—unless new behaviours are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed.

Kotter¹⁵

A critical success factor of any change strategy is whether the change effect is maintained and evolves over time. An improvement that evaporates as soon as the resources or focus are taken away, or gradually declines over time is of limited benefit.⁶

Sustainability therefore has been defined as ‘the extent to which new ways of working and improved outcomes have become the norm’.⁶ To achieve this, changes need to become embedded in the organisation’s structures, systems and resources.³

Critical success factors that maximise the potential sustainability of any initiative include:

- ✓ planning for sustainability early
- ✓ actively engaging stakeholders to ensure that they understand potential benefits for themselves as well as service users
- ✓ ensuring sustainability is not a project with an ‘end-point’ but is a constant effort to embed change into the fabric of daily work
- ✓ providing adequate training and development of new skills
- ✓ aligning change with core values and skills
- ✓ developing mechanisms to measure the change in an ongoing way
- ✓ demonstrating how change has improved performance
- ✓ encouraging continuing evolution so that today’s innovation does not become tomorrow’s resistance.

3.1.3 Spread

Spread is the conversion of information about one person’s practice into another person’s know-how.

Nutley and Davies³

While sustainability is focused on maintaining improvements within the local context, ‘spread’ focuses on the innovation being taken up by others in different settings.

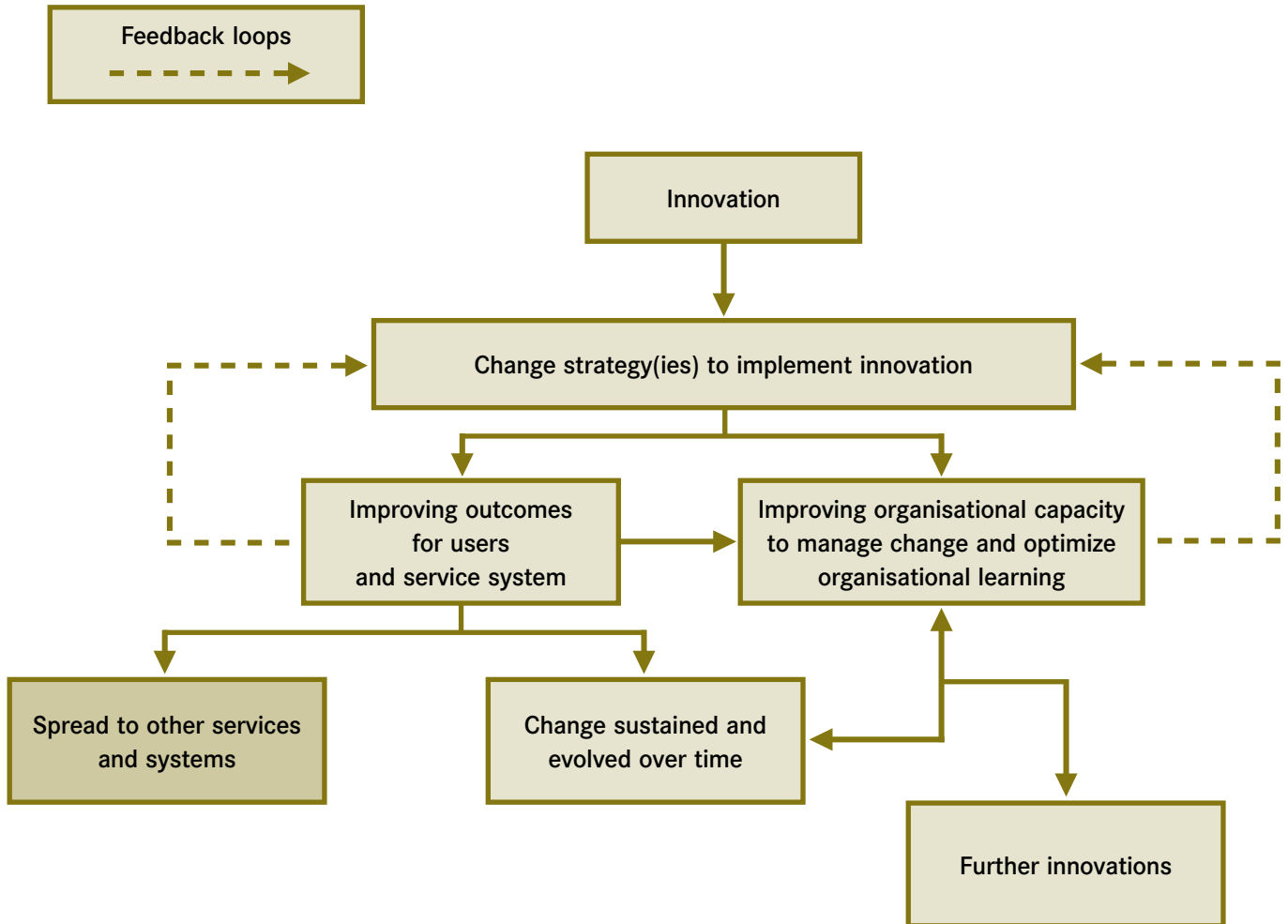
In particular, spread is defined as the extent to which learning and the underlying principles are adopted by other parts of the same organisation or across organisations.⁶ Importantly, spread is not the rigid adherence to specific improvement actions that worked within one setting.

Other terms used for ‘spread’ are adoption and diffusion.⁶ Optimally spread results from creating an opportunity for others to adopt change initiatives.

Spreading sustainable change leads to improvements within and across systems (See figure 1 on page 8).

Spreading sustainable change leads to improvements across systems.

Figure 1: Spreading sustainable change



3.2 Achieving and spreading sustainable change

In order to achieve and spread sustainable change, there are unfortunately no specific recipes or 'quick fixes'.³

In health care, a wide range of interventions such as clinical auditing, educational programs and general practice reminder systems have been trialled. All have been found to be successful in some situations but not in others.^{6, 21} One-off events, didactic lectures, and unsolicited dissemination of materials are least likely to produce change,¹⁷ although they may be useful for increasing general awareness.²²

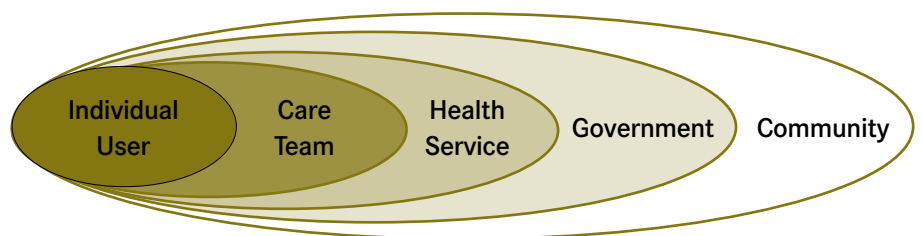
Although there is some contradictory evidence,¹² it is generally agreed that multiple interventions work better than single interventions. What is crucial is that interventions address the identified barriers to change.^{21, 22}

While there is growing understanding of the factors that influence individual behaviour, it is clear that many of these factors lie within the broader system.

Changes in practice at an individual, team or service level may be constrained if there are no corresponding changes within the system as a whole²³ (see Figure 2).

Interventions need to address the barriers to change. Multiple interventions work better than single interventions.

Figure 2: The individual user, the care team, the service and the system



Evidence also indicates that what prevents or assists organisational change varies in different settings. What is important and possible in one setting may be quite different in another.²⁴

The following discussion focuses on some of the key factors that influence change particularly those relevant to the experiences of the Breast Services Enhancement Program. These are:

- the nature of the innovation
- the organisational environment
- differing approaches to organisational change
- leadership
- time and resources.

However, there are complex and interchanging interactions between these and other factors and both the factors and the interactions vary within and between settings.⁷

Unless understood and successfully addressed these factors present **barriers** to achieving organisational change.

There is no one recipe for organisational change. Complex and interchanging interactions between multiple factors vary within and between settings. Unless addressed, these factors can become barriers to change.

3.3 The nature of the innovation

An innovation is defined as an ‘idea, practice or object perceived as new by an individual or by the unit of adoption.’²⁵ Evidence based guidelines are seen as an innovation.³

Specific attributes of an innovation influence its rate of adoption.²⁵ An idea or innovation is **more** likely to be adopted if it is:

- ✓ perceived to be better than the past idea
- ✓ compatible with existing values, past experiences and the needs of the potential users
- ✓ able to be experimented with or adapted and can be tested
- ✓ able to demonstrate observable results to others.

An idea or innovation is **less** likely to be adopted if it is:

- ◇ perceived to be difficult to understand or use.

Change is particularly difficult when an innovation requires:²¹

- complex changes in clinical practice
- better collaboration between disciplines
- changes in the organisation of care.

The complexity of health care reform therefore may require significant systemwide change, rather than just ‘tinkering at the edges’.²⁶ Long-term incremental approaches to change are needed that work at several different levels within an organisation and address underlying organisational values and attitudes.

The complexity may be further increased when the introduction of a new practice requires a new approach or system that is an innovation in itself.

3.4 Creating an organisational environment for change

An organisation’s effectiveness and its capacity to change are linked to its environment and culture.¹⁸

In some studies, health care cultures that value group affiliation, team work and coordination demonstrated a greater number of quality improvement initiatives than those that emphasised formal structures and stronger regulation and reporting mechanisms.¹⁸ In addition, an organisational culture of rivalry and competition may be a barrier to creating the collaborative environment needed for change.²⁶

Critical success factors in developing an effective culture that embraces change and quality improvement is the need to:

- ✓ build a supportive, safe and non-punitive environment that encourages innovation, risk taking and the capacity to challenge⁷
- ✓ foster collaboration rather than competition¹⁷
- ✓ value the contribution of the individual and the team¹⁷
- ✓ build individual and team capabilities³

- ✓ encourage team learning through reflection¹⁹
- ✓ start small¹⁵
- ✓ measure and celebrate short-term wins.¹⁵

To achieve this culture in health care, consideration must be given to a number of tensions that may exist.

3.4.1 Managing the tensions of organisational change in health care

It is well recognised that organisational change evokes anxiety in all organisations, but this anxiety may be exacerbated in health care organisations. This may be because of the inherent tension underlying the system, which is caused by the increasingly complex and high risk nature of its work. Organisational change in this environment therefore may be particularly challenging.²⁷

Unlike other organisations, health care organisations also have an inverted power structure, whereby professionals—particularly medical practitioners—have much greater control of day-to-day decision making.²⁰

Professional autonomy, rivalry and competition may exist within and between organisations, and there can be differences and conflict between organisational and professional cultures.^{20, 26} In addition, Ham²⁰ argues that, at times, medical practitioners may not be supportive of others taking up clinical leadership roles. As a result, Davies et al²⁶ contend that many health care reforms have done little to challenge deeply entrenched cultures and powerbases.

The increasing systemwide emphasis on improving the quality of patient-centred care and accountability may challenge professional autonomy. Ham²⁰ argues that substantial change is only likely when managers and clinicians work together to introduce new ways of working, which will not only improve the experiences of patients but also benefit the clinicians.

The capacity to ‘reflect on experience’ presents another challenge to the system. Within many health care disciplines’ education and practice, the emphasis is on ‘doing and thinking’, rather than reflection.²⁰ Therefore a tension exists between ‘doing’ and ‘learning about doing’. This is further compounded by the significant work demands within the acute care sector.³

Finally, there is further tension between the organisational imperative to bring about long-term cultural change and learning, and the external—and often political—imperatives for accountability, ‘quick fixes’ and readily measurable outcomes.³

These and other polarities are endemic in organisational change.²⁸ Rather than adopting an ‘either/or’ perspective, the coexistence of these polarities needs to be clearly acknowledged and managed.^{16, 28} For example, it is not the case of an organisation being responsive or resistant to change; rather, depending on the context and the change to be introduced, the organisation may be both responsive and resistant to change.

Contradictions and tensions coexist in organisational change and need to be managed.

3.4.2 Early and later adopters of change

Rogers²⁵ provides a useful framework for understanding how individuals (and organisations) may take up change at different speeds. Adopters are described to be in one of five categories:

- innovators
- early adopters
- early majority
- late majority
- ‘laggards’.

Again, all individuals or organisations may reflect different adopter categories at different times.¹⁶ It is also crucial to understand the concerns and questions of the later adopters (those being late majority and ‘laggards’). Their resistance may not be ‘resistance for the sake of resistance’, but may result from genuine concern about how a change may be evolving.

Listening to, rather than dismissing, the concerns of later adopters may result in:

- more realistic expectations
- improvements in the change itself leading to enhanced service outcomes.¹⁶

3.4.3 Other environmental factors that influence organisational change

Other environmental and social factors that influence the uptake of change include:³

- Organisations with a long history of success are less likely to adopt new approaches.
- Low environmental uncertainty increases the tendency of the organisation to remain stable and avoid change. Kotter¹⁵ argues that the first step in organisational change is to create a sense of urgency.
- While early adopters of change (either individual or organisational) may do so because of the evidence and the desire to improve practice. The need for legitimacy amongst peers may provide the trigger for ‘later adopters’.
- An organisational culture of innovation.
- The influence of the social network.
- Pressure from service users (consumers).
- Realistic timeframes and resources for achieving change (see Section 3.7).

Individuals and organisations take up change at different speeds. Understanding later adopters concerns can optimise service improvements.

3.5 Approaches to organisational change

3.5.1 Top-down or bottom-up change?

Another tension in organisational change is whether such change should be driven from a top-down approach—or supported from the bottom up.

A top-down or centralised approach is often aimed at changing the whole system, whereby broad organisational goals and approaches are established.²⁹ In a bottom-up or decentralised approach, the focus is more on individual practitioners or organisations and facilitating strong local ownership of the change.³

Both approaches have advantages and disadvantages identified in Table 1.

Table 1: Advantages and disadvantages of top-down and bottom-up approaches³

Approach	Advantages	Disadvantages
Top-down—centralised	<ul style="list-style-type: none"> • central quality control of which innovations to introduce • can introduce innovations for which there is as yet no felt need 	<ul style="list-style-type: none"> • user resistance to central control • may result in low adaptation to local circumstances
Bottom-up—decentralised	<ul style="list-style-type: none"> • high degree of user control • strong local ownership with closer fit between innovations and user needs and problems • users like the approach 	<ul style="list-style-type: none"> • possibility for ineffective innovations to be diffused because of lack of quality control • not suitable for diffusing innovations for which there is no felt need • local users, who control the introduction of change, may lack knowledge about other users' problems and about available solutions • may result in maintenance of the status quo

In reality, it is not a case of selecting centralised *or* decentralised approaches to change. These approaches should be seen as residing on a continuum, with organisational change being achieved through the right balance of centralised and decentralised control. The point selected along the continuum is contingent on the organisation and the situation, and may need to change over time.^{3, 15}

As part of this continuum, the right balance must also be created between the ‘push and pull’ (or ‘stick and carrot’) approach to change. With the top-down ‘push’ comes demands or levers to comply with certain change initiatives, whereas the ‘pull’ approach provides more supportive mechanisms, such as resources and training to encourage change. ‘Push’ and ‘pull’ mechanisms for organisational change can arise from external bodies (such as funding bodies) or internally, from executive or leadership groups within an organisation.^{3, 15}

Given the high level of professional autonomy in health care, a strong emphasis on a top-down ‘push’ may have limited impact. Any change achieved may be very fragile and potentially unsustainable,²⁰ and do little to change the underlying organisational culture.²⁶

To achieve significant health care reform, professional groups need to be engaged with the process through a strong bottom-up perspective and with the provision of supportive mechanisms.²⁰

3.5.2 Models and tools for developing change

Regardless of the point selected along the top-down/bottom-up continuum, different models and tools can provide useful approaches for change.

Langley et al’s³⁰ model of improvement provides a clear framework for progressing change through asking three key questions:

- What are we trying to achieve?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

This is then followed by the plan, do, study, act (PDSA) cycle. This structured quality improvement cycle enables testing of an idea by putting it into effect on a temporary basis and learning from its initial impact. If successful, the idea can then be sustained and built on within the same setting and spread in an incremental way across other parts of the system.

As indicated in Figure 3, key elements of the PDSA cycle are:

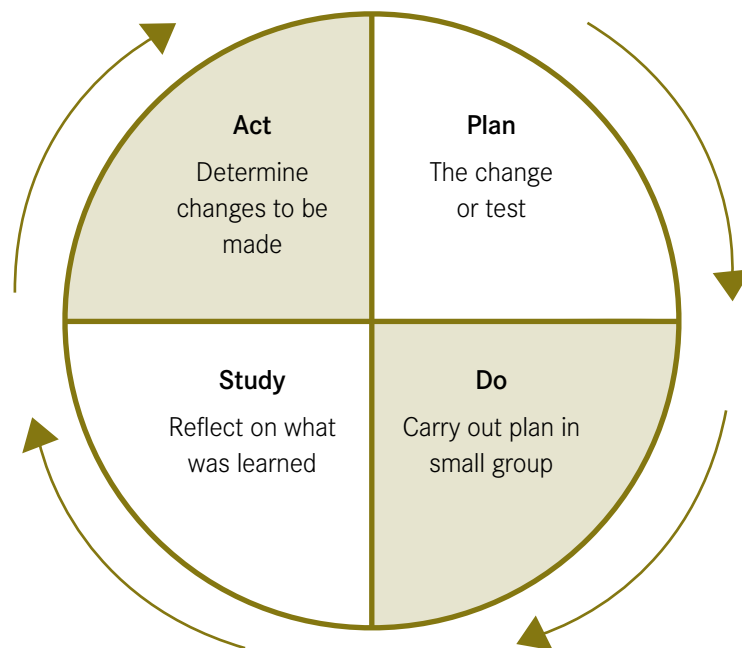
Plan: plan the change to be tested or implemented

Do: carry out the test or change

Study: study data before and after the change and reflect on what was learned

Act: plan the next change cycle or full implementation of change strategy.

Figure 3: The quality improvement cycle



This quality improvement model has been used extensively as a specific tool for quality improvement. It can be particularly useful when introducing initiatives that are amenable to ready measurement of improvements such as process redesign.

The emphasis on testing and developing ideas on a small scale and measuring success early:

- ✓ encourages learning from both successful and less successful innovations¹⁶
- ✓ strengthens local stakeholder ownership¹⁶
- ✓ encourages further change¹⁶
- ✓ increases willingness to tackle bigger problems¹⁵
- ✓ potentially reduces resistance³¹
- ✓ may stimulate broader cultural change.¹⁶

This model can provide a useful framework for the planning and development of broader organisational change and in informing practice in general.^{3, 16} In this broader context the model links in with an action learning approach to organisational change.

In action learning there are similar continuing cycles of planning, action and review to facilitate change and increase understanding of factors that influence change. Action learning brings a strong emphasis on reflection, collaboration between stakeholders in all aspects of the action learning cycle, and on developing the skills of those involved in the activity. In addition, an underlying value of action learning is to challenge the mindsets of organisations and individuals.³²

While the PDSA cycle may have a stronger focus on ‘doing what we do better’ (single-loop learning), action learning may be more in line with second-order change or ‘double-loop’ learning.^{18, 19}

However, the success of any quality improvement or action learning models also depends on creating a supportive environment (see Section 3.4) and on other organisational factors, including leadership.

3.6 Leading organisational change

Leadership is critical for organisational change.

Leadership is critical for championing any organisational change.¹⁸ There is an increasing emphasis on developing leadership teams, rather than leadership being embedded in heroic individuals.²⁰ In addition, leadership of organisational change must be positioned at both strategic and operational levels of organisations,¹⁴ with executive sponsorship being a critical requirement.¹⁵

Within health care leadership, the increasing emphasis on clinical governance is creating a culture of equilibrium between professional autonomy and accountability.²⁰ Substantial change is also likely to occur when both managers and clinical leaders or champions work together to introduce new ways of working.^{7, 20}

Whether leadership is embedded in managerial roles, clinical roles or in the role of internal or external change agents, a number of factors for leadership in organisational change have been identified. These **critical success factors** include the ability to:⁷

- ✓ create a safe environment to facilitate innovation and risk taking
- ✓ build coalitions and collaborations
- ✓ develop and strengthen teams that encourage more collegial, rather than hierarchical or competitive relationships
- ✓ articulate a clear vision and purpose
- ✓ enhance organisational and individual adaptability to change
- ✓ establish high performance expectations.

In addition, Moss Kanter⁴ argues that leaders need to:

- ✓ use imagination to build innovation
- ✓ challenge prevailing organisational wisdom
- ✓ identify opportunities and gather information from a range of formal and informal sources.

Importantly, in facilitating cultural change over time, clinical leadership in particular may play a vital role in encouraging the incorporation of these values:²⁶

- the centrality of patient care
- a belief in evidence based practice to support clinical decision making
- a willingness to examine quality issues.

3.6.1 Change agents and opinion leaders

While the role of ‘change agent’ may be incorporated into clinical leadership and managerial roles, at times it may be given to others. The internal or external change agent’s capacity to influence change may be influenced by their contact and credibility with the potential adopters of change.³³ Given that multifaceted interventions work best when tailored to the organisational context, change agents need to be skilled tailors to achieve this match.³

Opinion leaders are similar in status and outlook to potential adopters of change and can be used to ‘champion’ the uptake of change. However, opinion leaders alone may be insufficient to evoke the necessary change.^{3, 21}

If change agents and opinion leaders work in partnership, there is greater likelihood of the change being taken up.²⁰

Change agents and opinion leaders can work together to increase the uptake of change.

3.6.2 Authority and leadership

Effective leadership needs ‘authority’—that is, the right to make an ultimate decision, which, within an organisation, includes the right to make decisions that are binding on others.³⁴

Authority may come from one’s position or role within the system—this is called formal or positional authority. This authority is also influenced by whether it is sanctioned or not by others within the system. Authority also arises from within the individual, based on their life experience and self-confidence—this is called personal authority.³⁴

Formal leadership will be limited if it is not sanctioned by others, and/or the incumbent has limited confidence in their own personal authority. Where they have limited formal authority, the capacity of an individual to influence others in an informal leadership role may depend on their personal authority and their role being sanctioned by others.

Flexibility and creativity within the system can be achieved through effective delegation of authority and the appropriate use of personal authority to facilitate the development of self-managed teams.^{34, 35}

Finally, the use of appropriate authority needs to be distinguished from an authoritarian approach in which an individual may inappropriately draw on power that is coercive and renders others powerless.³⁴

Effective leadership needs authority—either positional, sanctioned by others and/or personal authority.

3.7 Time and resources for sustaining organisational change

While some innovations and changes within health care may be readily adopted, many changes require new mindsets and take time to sink deeply into the organisation's culture. Until this happens new approaches remain fragile and subject to regression.¹⁵

If change is premised on the development of new partnerships and teams, then time and resources are essential to help people get to know each other before they can build the necessary trust for change.⁴ From another perspective, the development of mutual trust and collaboration may be an 'end point' of an activity, rather than the starting point.³⁶ From this end point, the momentum for incremental change may increase exponentially with optimal change seen over several years. Kotter argues that optimal organisational change takes seven years.¹⁵

Collaboration between stakeholders takes time for mutual trust to develop – or it may be an outcome of specific activities with a clear purpose.

Celebrating early successes is an important component of organisational change, enabling bigger problems to be tackled.¹⁵ However, Kotter¹⁵ warns that change initiators and change resisters may jump on the small wins, and consciously or unconsciously collude to create the 'premature victory'. This 'victory' may kill momentum to sustain and spread the change.

Celebrate successes but avoid declaring victory too soon.

While there is general agreement that change takes time and resources^{4, 14, 15, 20} it contrasts with the impatience of reformers and funding agencies seeking the 'quick fix'. Managing this tension remains challenging.

3.8 Evaluating organisational change in health care

Innovations to improve health care service delivery (such as clinical audits or service provider education) are often initially tested in ideal and controlled trial circumstances. However, such trials rarely offer insights into why one intervention works better than another, and in what context they work.¹³

Even if successfully tested, it is much more complex to encourage the adoption or spread of these innovations into usual practice when a whole range of 'real life' factors may affect their uptake. The uptake of innovations and the achievement of outcomes are also more difficult to achieve and to measure when they depend on changes in the underlying organisational culture.³

While it is important to measure small successes,¹⁵ tensions remain between what is measured as success. For some the focus is on demonstrating clear and early outcomes, whereas for others the early focus is on establishing successful implementation of processes. Measuring success can also involve an economic evaluation, including a cost-benefit analysis.³⁷

Ovretveit³⁷ argues that unless good processes and outputs can be first demonstrated, then longer-term outcomes are unlikely to be achieved.

Given the complexity of organisational change in 'real life' settings and competing views, it is not surprising that evaluation of innovations and organisational change may be less rigorously undertaken or omitted.¹³

4 Learning from the Breast Services Enhancement Program experience

As the flagship of the Breast Disease Service Redevelopment Strategy, the Program enabled local services to develop and trial service improvements. It also became a vehicle for the development or trialling of other statewide initiatives.

4.1 Where we started

The Program was initiated to:¹

...redevelop breast services through collaborative planning, identification of a coordinator for each model, establishment of strategic links between service providers, and the achievement of a range of outcomes associated with best practice...

Given these broad parameters, the Program evolved over time as we gained understanding of some the challenges that arose as it was implemented. All providers were encouraged to use the opportunities that the Program offered to make further service improvements, regardless of where they were on a continuum of ‘best practice’.

4.2 The key themes

This learning resource draws on the experiences of the Breast Services Enhancement Program—from its early development to its completion. There were a great number of successes and achievements, but many took significant time, energy and commitment. Perhaps a good measure of the Program’s success has been the willingness to articulate the learnings gathered from the successes, challenges and tensions that had to be managed.

The next section summarises the key Program learnings for supporting sustainable change.

Section 6 explores some of the critical success factors and barriers in more detail, in order to provide the evidence behind these learnings. Section 7 specifically considers mechanisms of measuring and sustaining success.

5 Supporting sustainable change –key Program learnings

5.1 General learnings

- Achieving organisational change within health care systems is challenging. It is influenced by multiple, complex and interacting factors, contingent on the organisational context. These findings are in synergy with the literature.
- As an innovation, the improved uptake of evidence-based guidelines requires innovation or changes in clinical practice, enhanced collaborative relationships between disciplines and changes in the organisation of care. It also requires changes in mindsets and organisational culture. This requires complex organisational change.
- **There is no one recipe for change.** Depending on the setting, different factors will assume greater or lesser importance.
- Key factors in facilitating change include:
 - a balance of top-down and bottom-up levers ('push') and support ('pull')
 - providing time, resources and flexibility
 - creating a supportive and collaborative environment
 - leadership, local champions and opinion leaders
 - program staff as change agents
 - executive sponsorship.
- While all factors are important, **effective local leadership in partnership with program staff as change agents is crucial to achieve change.**
- Significant change often needs action at multiple levels across a system. At times, changes in one factor alone may trigger the desired change.

5.2 Leadership

- Supportive and effective leaders are essential to champion change. They may be found in external funding bodies, within internal organisational roles, designated clinical coordinators or opinion leaders.
- The effectiveness of clinical coordinators and other leaders may be influenced by their authority within the system, and by personal, political and professional imperatives.
- External, powerful and respected opinion leaders can be useful to facilitate change when there is significant resistance.
- As change agents, program staff need to:
 - have or develop a wide range of skills in organisational change and project management
 - establish their legitimacy and credibility with stakeholders
 - be able to draw on personal authority
 - work in partnership with local leaders and other stakeholders.

- Program staff and leaders need to understand the context of all relevant services, be able to manage contradictions and tensions, and build bridges between stakeholders.
- All leaders and change agents need to be alert for unexpected opportunities and levers that facilitate change.
- Additional support through education and skills development is needed to strengthen leaders', clinical coordinators' and other change agents' roles in organisational change.

5.3 Top-down and bottom-up approaches

- To optimise successful organisational change within the health sector, a balance is needed between top-down and bottom-up approaches. A top-down approach needs to provide broad program parameters and support the change through incentive funding and other mechanisms.
- A strong bottom-up and incremental approach to change facilitates strong local ownership by stakeholders.
- At times, local stakeholder interests and resistances limit the uptake of change. A top-down supportive leadership approach (pull) with the judicious use of levers (push) can create a sense of urgency and legitimacy to facilitate the required change.
- Local executive sponsorship is essential for more service or systemwide change, to resolve problems within consortia and facilitate sustainability. Such executive sponsorship requires a broader health agenda such as an 'all cancer' program.
- Central coordination is needed to reduce unnecessary duplication of locally driven initiatives, facilitate shared learning and optimise sustainability and spread of some initiatives.

5.4 Developing collaborative relationships

- Developing and maintaining consortia of services to implement health care reform needs to accommodate the different organisational profiles, interests and cultures of each service and manage pre-existing conflict and rivalry.
- As trust grows, stronger collaboration may occur between consortia partners.
- Creating opportunities to work together on specific tasks also facilitates the development of mutual trust and collaboration between previously competitive service providers.
- The establishment of consortia helps to facilitate the spread of innovation across services.

5.5 Measuring and sustaining change

- Evaluating organisational change is complex, and requires significant resources and skills to capture subtle changes that will lead to future improvements and enhanced consumer outcomes.
- Key factors enabling the sustainability of change include:
 - demonstrated benefit
 - early embedding of functions or roles in organisational norms, practices, structures or funding mechanisms
 - improved service capacity and leadership for future change.
- Where sustainability of newly funded positions is threatened, stronger dialogue is needed between stakeholders in local health services and the Department of Human Services. However, the single focus on one issue (breast cancer) limits the ability to incorporate new initiatives into current funding mechanisms or new funding approaches based on a broader funding model.
- Consideration at a departmental and local level needs to be given on how better to maintain interest and momentum in sustaining change, rather than the continuing drive for the next innovation.

6 The Breast Services Enhancement Program journey

As a complex initiative, the Program crossed boundaries between organisations within a consortium, across consortia and between the consortia and the Department of Human Services. Conversely, the Program was constrained by boundaries within and between specific organisations, and by the boundary of being a ‘breast cancer-specific’ program.

The Program learnings came through understanding and managing these and other contradictions and differing perspectives.

I think you learn from what hasn't worked, you remember the personalities and the politics and try to work around it and understand it.

Oncologist

However, this also needs to be done in the context of the Program's achievements and successes.

6.1 Setting the scene—the Program structure

Within each consortium, a lead agency was nominated and a steering committee established with representatives from all consortium members to guide the local Program directions. Within some consortia, the steering committees included executive membership, as well as representatives from different clinical disciplines and consumers. Along with Program staff, a clinical coordinator role was established within each consortium.

In addition to the steering committees, consortia established working parties to develop specific projects in more detail.

6.2 Setting the scene—achievements

The Program's achievements, as highlighted in Table 2, cover the Program's four priority areas of improving women's access to:

- multidisciplinary care
- breast care nurse practice
- quality information, support and communication
- improved continuity and integration of care.

Table 2: Breast Services Enhancement Program—major achievements

Program Focus	Major activities and achievements	Consumer benefits/outcomes
Improved access to multidisciplinary care	<ul style="list-style-type: none"> • Twelve new multidisciplinary (MD) meetings established and nine meetings strengthened for management of women with early breast cancer. • MD clinics established at two sites. • MD video provides insight into women’s understanding of MD care. • MD care protocols/pathways developed to support local providers. • MD audit tool demonstrates that quality of MD processes can be quantified and used to improve practice. • Breast disease clinical databases established in five consortia. • Lymphoedema services established or strengthened in several consortia. 	<ul style="list-style-type: none"> ★ Positive management outcomes directly demonstrated for individual women, and indirectly, through changes in providers’ practice and improved continuity of care. ★ Databases have the potential to facilitate monitoring of best practice processes and clinical outcomes. ★ Improved women’s access to lymphoedema services.
Improved access to breast care nurse practice	<ul style="list-style-type: none"> • New breast care nurse positions established and sustained within services and across services. • Trial of rural regional breast care nurse coordinators to support local BCNs in their practice. • Breast care nurse networks formally established across services within six consortia. Specific projects within other consortia facilitated informal networks. • Strategies used to support BCNs practice included education and skills updates, professional supervision and establishment of breast care nurse database. 	<ul style="list-style-type: none"> ★ Women have improved access to BCN at key points in pathway. ★ Improved women’s referral across BCNs and service sites. ★ Improved consistency of care for women across services
Improved access to quality information, support and communication	<ul style="list-style-type: none"> • Development of consistent information packs for consumers at different points in pathway. • Information packs contained clinical information and information about local support services. • Specific resources developed for women with benign conditions and young women with breast cancer. • Service and resource directories developed. • Short-term and ongoing educational and support programs developed. • Trial of psychosocial assessment and referral approaches in five consortia. • Family therapy service trialled. 	<ul style="list-style-type: none"> ★ Women’s knowledge and decision making improved with provision of consistent information across pathway ★ Psychosocial needs of women better identified optimising specific psychosocial referral and/or care provided.

Program Focus	Major activities and achievements	Consumer benefits/outcomes
Improved continuity and integration of care	<ul style="list-style-type: none"> • MD meeting established for women with advanced breast cancer. • General practitioners integrated into multidisciplinary team meetings in two consortia. • GP telephone case conferencing trialled. • Patient-held records trialled in three consortia. 	<ul style="list-style-type: none"> ★ Women’s care improved through enhanced clinical decision making. ★ Patient-held records facilitated women’s improved knowledge of their individual treatment and assisted them to navigate the system.

The Program started slowly, but gradually built momentum as stakeholders came on board and engaged in the process.

When we started, I thought that we had a pretty good service. I couldn’t see how we could make a difference. But now, I can’t tell you how much it has improved.

Clinician

Underpinning these achievements was the development of trust and collaboration between stakeholders, increased skills and knowledge and improved capacity for further change.

However, given the nature of the Program, with its strong bottom-up approach and its specific focus on one entity (breast disease), much of the focus of the improvements were at the level of the care team, with smaller improvements at the broader health service or system level.

A number of other factors influenced the Program achievements. The following table summarises the critical success factors and challenges or barriers faced by the Program.

Table 3: An overview of the Program’s success factors and challenges

Critical success factors	Challenges or barriers
✓ the provision of financial, staffing and other support resources	◇ lack of time and resources
✓ capacity to trial local initiatives encouraging strong local ownership	◇ an environment of competition rather than collaboration
✓ the role of a clinical champion with the authority to influence practice	◇ lack of clinical leadership
✓ program flexibility	◇ resistance to change
✓ synergies with statewide projects that provided external push or pull for change.	◇ limited executive support

The following discussion considers these issues under some common themes. While presented in a linear manner, there are strong interactions between all the key theme areas and elements within them.

6.3 Developing and implementing innovation

The understanding of the complexity of the required innovation, and change was perhaps a major learning for the Program.

As indicated in Section 3.3, the inherently complex nature of the Program’s change agenda to facilitate the uptake of evidence-based guidelines required new approaches, practices, products and systems. It also required changing underlying mindsets and organisational cultures. The Program stipulation—to have consumers actively involved in all levels of program infrastructure—also provided challenges and new ways of working.

Where processes such as multidisciplinary teams were already in place, the change focused on improving processes (single-loop learning). In other services, the starting point was first to establish the need for a multidisciplinary process, and then develop the processes to facilitate effective team development. Only after this was achieved came the opportunity to enhance clinical decision making and improve consumer outcomes. These processes had the capacity fundamentally to change aspects of practice and the system (double-loop learning).

In other instances, more concrete products, such as a patient-held record or information resources, had to be developed first. Once developed, the focus was on integrating their use into practice. Some innovations, such as establishing multidisciplinary and other specialist clinics, required significant local system change.

On reflection, at the start of the Program, the level of staff understanding about organisational change was assumed. The reality was that staff learned significantly ‘on the job’ throughout the Program’s life.

For more information on consumer participation in the Program, see *Building partnerships with consumers for improved service delivery*, another resource in this learning series.

In-service skills training in organisational change and project management may be a useful mechanism to support program staff involved in future health service reform and quality improvement programs.

The overall Program and staff within it may have benefited from more formal skills development in both organisational change and project management as part of the Program's support mechanisms.

6.4 Balancing a top-down and bottom-up approach

The start-up of the Program obviously resulted from the leadership and external top-down 'push' from the Department of Human Services, through the BreastCare Victoria Coordination Unit (the Coordination Unit). Stipulated key program features included the establishment of consortia and steering committees and the need for and the role of the clinical coordinator and program staff.

However this external 'push' was balanced with the Coordination Unit's much stronger supportive 'pull' of:

- ✓ incentive funding
- ✓ guidelines that provided initial and ongoing program directions, but were not prescriptive in approach
- ✓ ongoing support mechanisms for program staff through regular formal meetings and skills development opportunities, and the provision of informal support and feedback
- ✓ developing and supporting the project evaluation.

When needed through the life of the Program, the leadership from the Coordination Unit, with its judicious blend of a top-down 'push' and 'pull' provided the following **benefits**:

- ★ brokering solutions when consortia were unable to resolve substantive issues
- ★ funding specific initiatives so that it provided a lever to achieve other service improvements
- ★ facilitating the Program's involvement when opportunities arose to address broader problems within a local system (see Case study 2).

However, the much stronger Program emphasis was on a 'bottom-up' incremental approach which facilitated local ownership, and enabled stakeholders to identify local needs and develop and trial local solutions. Many successes were achieved.

I think it was a good concept, that each service worked out what was best for them. You decided what was best for your region and I think that's important. My impression of past programs is that some sort of commandment comes down from tall buildings: 'This is how you will do it.' And they just don't work, because there are so many situations... The concept of letting people achieve primary aims, but in their own way, is a model that should be followed.

The strong bottom-up, incremental approach facilitated strong local ownership.

Medical oncologist

This strong bottom-up approach presented some **challenges**, including:

- ◇ The lack of executive sponsorship at a service level resulted in limited local executive ownership and support that was needed:
 - to address some broader service and system changes required
 - to resolve problems within consortia
 - or to facilitate sustainability of successful initiatives.
- ◇ Similar projects being developed across several consortia resulted in some duplication and reduced opportunities for learning across consortia. Enhanced coordination could have reduced some duplication and strengthened shared learning (see Section 7.2.5).
- ◇ The need for strong local ownership of initiatives by all services within a consortium was time and labour intensive, and affected the timeliness of achieving outcomes.
- ◇ Maintenance of the status quo when Program staff had little influence to overcome significant resistance to specific initiatives. For example, the reluctance to document multidisciplinary meeting recommendations was only overcome when the statewide performance indicator pilot project was introduced. As an external push, this pilot project offered both legitimacy and some urgency for change.

6.5 Providing time, resources and flexibility

Originally conceptualised as a two year program, the Program evolved over five years. Even within the initial timeframe, the broad parameters of the program enabled stakeholders to ‘think’ and with the support of staff, to develop and trial a range of strategies.

I think it (BSEP) is a remarkable thing to happen for change in the health system... where power is more centrally controlled, to actually pour a bucket of money down to grass roots level and say, ‘You find the problem, you decide what to do about it and you go and do it’.

Clinical coordinator

Given the nature of the Program and what is now understood about organisational change, the original two-year timeline was ambitious. The additional time enabled programs to:

- ✓ build on initial achievements and develop new directions
- ✓ gain further achievements after initially encountering significant resistance
- ✓ strengthen sustainability of successful initiatives by embedding new practices into systems and processes.

The Program was very responsive—we knew where the patients were, where they were treated and what was going on before the program. As we went through the process we were able to go back to the Department and say, ‘We need to move in this direction—it’s not in our original plan, but here’s why’. And mostly, what we wanted to do was facilitated... there were synergies with other projects.

Clinical coordinator

Time was also crucial to enable shifts in mindsets. In discussing the impact of a multidisciplinary meeting, one stakeholder commented:

I don’t see direct evidence of changing how they (general surgeons) are managing women... what I do see is that it’s beginning to infiltrate their mindset, and I think that will eventually lead to change.

Radiation oncologist

These subtle shifts in mindsets were also seen in the later stages of the Program; where strong mutual trust existed, stakeholders were more able to reflect on factors influencing the uptake of change within their service. In addition, one unit head initiated strategic planning processes to maintain the impetus for future service improvements.

The provision of additional staff resources through the Program was essential to enable the translation of ideas into concrete projects. In contrast, when there was high Program staff turnover and long periods with limited resources, progress in achieving goals was constrained. In addition, where change remained reliant on Program resources, the withdrawal of these resources at the end of the Program, presented significant challenges for sustainability (see Section 7.2).

Time, resources and flexibility enabled services to develop trust, build on early achievements and strengthen sustainability.

6.6 Creating a supportive environment

In establishing the Program, the Coordination Unit aimed to create and maintain a supportive relationship with all stakeholders. In many ways, the Coordination Unit successfully ‘bridged the traditional purchaser–provider split’, and actively encouraged collaboration between the Department of Human Services and local service providers, as well as within and between individual consortia.

To foster this environment supportive of collaboration and change within consortia, consideration needs to be given to how alliances between services are better convened. The development of each consortium’s structure with the steering committee and subsequent working parties aimed to facilitate communication between consortia members (see Section 6.1).

Initial drivers for stakeholders’ involvement in the Program’s nine consortia included a commitment to improving services, wanting to influence the reform agenda and to ensure equitable access to incentive funding. However, differences between services that influenced how the consortia developed and how different members contributed, included:

- caseload
- the nature of the service for example a tertiary referral centre or a more community-based organisation
- the service's understanding of best practice in breast care
- other differing organisational interests and values.

These differences resulted in some services breaking away from designated consortia. Within other consortia, some services played more passive roles. At times, well-entrenched pre-existing rivalry between services remained an underlying tension to be managed by Program staff. Where significant conflict and distrust occurred, this affected the implementation of the service plan.

For more information about this service, see Case study 5 in the document *Continuity and coordination of care—improving the 'cancer journey'*, another resource in this learning series.

With the disengagement of one service, one consortium consisted of only a single health service at three sites. As a major breast service provider, this consortium was then less constrained by conflicting organisational interests compared with other consortia. The consortium's clear focus for improvement within the one health service, along with strong local leadership, resulted in significant service improvements and redevelopment. However, the single health service focus of this consortium constrained the 'spread' of successful innovations.

Within consortia made up of multiple health services, the organisational culture of each service appeared to influence the uptake of change. While not definitive, there was some evidence that early adopters of change occurred in smaller or somewhat younger organisations with a stronger community focus, and possibly a greater 'urgency' to demonstrate best practice. Less change, or later adoption of change, appeared in some larger tertiary referral services that may be more hierarchical and stable and perceived to be more successful.

Program staff played a critical role in understanding the different contexts of each service and bringing together services. Often real collaboration between stakeholders appeared as an outcome of specific tasks or activities within and across services. For example:

- The establishment of multidisciplinary teams enabled local service providers to get to know each other—often for the first time. This built trust and collaboration.

The fact that we now intellectually are on the same wavelength and we talk to each other, that's the critical thing.

Rural radiologist

- The development of specific projects across a health service with multiple sites and providers facilitated a culture of greater collaboration in sharp contrast to the previous competition and conflict (see Case study 2).

Finally, while establishing and maintaining the consortia had many challenges, the governance structure of steering committees and working parties facilitated the development of trust and dialogue between members over time. This enabled joint initiatives to develop, and provided a vehicle for the spread of change over a number of services (see Section 7.2).

Case study 2

Developing collaboration between competing services

Where we started

This health network in outer metropolitan Melbourne consisted of three hospitals and was part of one of the larger Breast Services Enhancement Programs. Traditionally, key providers in the three hospitals saw themselves in competition with each other.

During the life of BSEP, there was a change in the unit head in one service, and significant problems in the accommodation for breast services at another site. These problems were brought to the notice of internal and external stakeholders at both an executive and operational level. Informal discussions were held between executives in BreastCare, BreastScreen and the health service. BreastCare staff and the BSEP manager were aware of the issues and the potential opportunities.

What we did

Encouraged by the BreastCare Coordination Unit, an executive member of the health service established a working party with key stakeholders. There was agreement that the breast services at the different sites could work better together and provide more consistent care across services. It was also the start of a 'thawing' of relationships between some service providers.

With the support of BSEP resources, a number of initiatives were developed over the next 18 months, including:

- Development of a three-monthly multidisciplinary meeting across all three sites. Initially, each service presented their own cases using their own format. Over time, a common format was used so that case presentations became 'seamless', in many ways modeling how an integrated service might be for future consumers.
- There was increasing recognition amongst clinicians that a supportive, rather than adversarial, approach to multidisciplinary case discussion was more likely to influence practice.
- Development of shared pathways and protocols.
- Establishment of a multidisciplinary meeting for women with advanced breast cancer.

What we achieved

- Development of mutual trust and support, and greater collaboration in a previously antagonistic environment.
- This collaboration led to further improvements. For example, as there was significant inequity of breast care nurse resources across health service sites, the key clinical stakeholders agreed to review breast care nurse resources across all health services, with support from the nursing executive. The review was undertaken with funding from BSEP and the recommendations for change endorsed.

Critical success factors facilitating change

- ✓ balance of top-down and bottom-up support
- ✓ locally identified problems and ownership of initiatives
- ✓ BSEP resources used to achieve new strategies
- ✓ BSEP acted as 'change agent'
- ✓ collaborative relationships
- ✓ time
- ✓ unexpected opportunity seized.

6.7 Leadership and ‘championing’ organisational change

As indicated earlier, the Coordination Unit played an important leadership role in encouraging and supporting change.

Within each consortium, the Program’s success depended on the blend and quality of leadership from clinical coordinators, unit heads and others in positions of authority, breast care nurses, other opinion leaders and program staff.

Conversely, active and passive resistance to change found in some role incumbents significantly impeded progress. At times, the presence of the ‘anti-champion’ was as powerful or even more powerful than the ‘champion’.

6.7.1 The role of the clinical coordinator

The clinical coordinator role was an important but challenging role. The capacity to effect change depended on the role incumbent’s:

- position and authority within their own organisation
- ability to influence others, particularly within alliance partners
- understanding of and skills in organisational change
- own commitment, time and energy to the cause
- other personal, professional or organisational influences.

The allocation of funding for the clinical coordinator’s hours facilitated their active involvement in a range of projects.

While clinical coordinators came with commitment, enthusiasm and strong clinical skills and knowledge, most had more limited experience in organisational change. Stronger preparation for their role, particularly in the early Program phases, was needed to assist them in their role.

Lack of authority within the system severely constrained committed clinical coordinators’ capacity to encourage the uptake of change. At times, the clinical coordinators were aware of but unable to contain the undermining of Program initiatives:

I have ideas and enthusiasm and I’m good at diplomacy, but I have no authority in the organisation. What you really need is a person with authority, or a person to whom authority has been clearly delegated. Or else it becomes too hard, when people don’t want to do it. You get boxed off as: ‘Oh well, that’s what he does with the program staff and we don’t care about it’ and that has happened here....

Many of the powerful people with authority don’t want change, and if the agenda of the project is change, then there is a problem.

Clinical coordinator

Clinical coordinators (and other clinical leaders) need stronger skills development in organisational change to facilitate their capacity to take up their role.

It's quite tough, because it's very easy to pull down some new edifice that is being constructed. And there are people who, for all sorts of good and bad reasons, sometimes because they are losing power, sometimes because they are threatened by change or whatever... we saw examples of that with some senior people here. There are examples where three or four or five people acted in collusion to dismantle things... There were very powerful, very orchestrated events that startled me.

Clinical coordinator

The clinical coordinator role was most successful when it:

- ✓ worked in partnership with Program staff
 - ✓ was combined with that of the unit head, who had a commitment to change
- or
- ✓ was endorsed and actively supported by the unit head.

In some Programs, clinical coordinators with significant positional authority appeared to have difficulties using this to influence change, possibly constrained by other personal, political or professional imperatives. In other programs, clinical coordinators were appointed who clearly had limited authority or influence. These 'safe' choices may have been influenced by a desire not to upset local power bases. As a result, the power bases and the status quo were maintained.

A change in the clinical coordinator brought new enthusiasm and energy to some consortia. Stronger local executive engagement may also have assisted in facilitating the effective role of the clinical coordinators.

The clinical coordinator role needs to be actively committed to organisational change and, in the absence of positional authority, needs active support and delegated authority from formal clinical and executive leadership.

6.7.2 Opinion leaders

As local opinion leaders, unit heads played critical roles in creating an environment supportive of change. They played lead roles in services where the clinical coordinator had no formal authority and influenced outcomes. Where unit heads provided enthusiasm and championed change, greater improvements were achieved.

At times, unit heads worked quietly 'behind the scenes' to address more intractable issues and to influence longer-term system changes.

The visit of a national opinion leader to one consortium resulted in the immediate uptake of the desired innovation after a long period of significant resistance. At other times, a new staff member within a service—but not in a formal leadership role—was able to generate change.

Unit heads and other opinion leaders played an important role in influencing the uptake of change.

6.7.3 Role of consumers

Consumers also played an important role in influencing change within some consortia, and particularly within specific projects. In some projects, such as the development of patient-held records and information resources, consumers' opinion directed the content, flavour and design of resources.

Consumer support also provided some consortia with stronger legitimacy for their initiatives:

The input of consumers was absolutely critical. That's the first time we have had the opportunity to have consumer input to what we were doing... they gave us good advice... and gave us support to do things we also thought were important... not only did we think they were important, but they did as well. That gave the whole process a legitimacy that others might not have had.

Clinical coordinator

For more information about working with consumers, see *Building partnerships with consumers for improved service delivery*—another resource in this learning series.

6.7.4 Program staff as change agents

To successfully facilitate change, Program staff needed to have or develop:

- ✓ a wide range of skills in organisational change and project management
- ✓ legitimacy and credibility with stakeholders
- ✓ in the absence of positional authority, the ability to draw on their personal authority and influence
- ✓ a clear understanding of the different contexts in which services operated
- ✓ the capacity to build bridges across services.

Some Program staff came with legitimacy and credibility from their previous roles within the system, or from their professional background. Regardless of professional background or skills, other staff had to earn legitimacy and credibility through building relationships and trust with key stakeholders, and by getting 'runs on the board'. Gaining this legitimacy positively impacted on staff's ability to take up their personal authority and enabled them to ask critical questions, raise issues and negotiate change.

Personal authority was eroded when staff had greater difficulty gaining legitimacy and credibility. This occurred when staff were perceived to:

- come from different professional backgrounds
- hold different philosophical approaches
- be more aligned with a competing stakeholder.

It also occurred when there was overt or covert stakeholder resistance.

Some of this stakeholder resistance arose from the limited overt acknowledgement of the Program staff as 'change agents'. Rather, some stakeholders saw staff only as additional resources with a very limited role or authority to influence change. However, in other consortia, and with other service providers within consortia, Program staff were able to influence change.

Perceived as both internal and external to the service team but relatively neutral, project staff provided both a subtle 'push' and 'pull' to achieve change:

...a lot of the process where you think it's (service) all okay, it's only when people come from outside and start to look at things from a different angle that you start to think and appreciate that it's not quite as good as you thought... The program manager triggered our thoughts on how to improve breast cancer management.

Clinician

This 'push' was then followed by the strong 'pull' of supporting initiatives for change.

They (the staff) have done a lot of work... that on our own we wouldn't have been able to do, with time constraints...

Clinician

While at times, Program staff considered they had limited influence, their presence alone was seen by some stakeholders as a powerful and constant reminder of the need to enhance practice.

As change agents, Program staff were most successful when they were able to:

- ✓ work in partnership with the clinical coordinator or other team leaders
- ✓ work collaboratively with all stakeholders and encourage local ownership
- ✓ be alert to new opportunities
- ✓ make linkages across services and Programs
- ✓ optimise spread of change within the consortium and across consortia
- ✓ strengthen sustainability by:

- embedding functions initially undertaken by Program staff into established roles
- building the capacity of service staff to take on new responsibilities
- brokering access to ongoing funding or resources
- ✓ gather personal support for themselves within their role.

Where Program staff worked in isolation, with limited support or active resistance from clinical leaders and no executive support, it was very difficult to achieve substantial change.

Program staff played a critical role in supporting change. To be most effective they needed to use a wide range of skills, gain legitimacy and credibility with stakeholders, use personal authority and work in mutually supportive partnerships with team members.

6.7.5 Executive sponsorship

Where executives were represented on consortia steering committees, the following factors appeared to **challenge** their role as executive sponsors:

- ◇ the nature of the Program across several services reduced the sense of local service ownership
- ◇ the specific focus on one condition (breast cancer) did not provide a 'critical mass' to stimulate broader system change
- ◇ financial constraints resulted in executives being reluctant to provide ongoing funding for initiatives as this might have set a precedent for other units within their service.

The overall Program would have benefited from stronger and more formal local executive support and leadership.

In one Program that experienced significant problems, the development of a formal memorandum of understanding between services and the establishment of an executive committee provided additional structure to manage stakeholder interests and facilitate progress. While beneficial, some of these executive stakeholders held expectations different from those of the clinical stakeholders adding an additional tension to be managed by Program staff.

Finally, in some Programs, individual executives played an important but informal role in supporting initiatives. However, changes in executive staff, competing workloads and priorities and the lack of formal executive engagement limited the executive capacity to support specific initiatives.

7 The challenge of measuring and sustaining success

A measure of a program's success is that there is clear understanding of the program's benefits, and that these benefits have been sustained over time. In addition, an understanding and articulation of factors that influenced a program's success and challenges creates the opportunity of learning for the future.

7.1 Measuring success

Evaluating the success of the Program raised significant challenges.

First, in terms of what was valued as success, some stakeholders wanted to see early and clear demonstration of improved consumer outcomes. Others recognised the longer-term nature of organisational change and were more focused on evaluating changes in processes and in demonstrating improved capacity for future change.

Second, stakeholders highlighted the difficulties of evaluating organisational change, and that formal evaluation would not necessarily capture subtle changes. Still others indicated the need to try to capture clear or subtle outcomes through qualitative processes. Without this, there would be little evidence to support the staff's perceptions that 'real change' had taken place.

Third, the evaluation was challenged by the complex nature of the Program within and across nine quite different consortia with different services, cultures and priorities.

7.1.1 Approaches to evaluation

The evaluation was undertaken at several levels across the Program. First, evaluation was undertaken at the individual program and project level. This evaluation fed into a broader evaluation of the four priority areas across all Programs, which then led into a broader 'whole-of-program' evaluation.

Consortia were supported to develop and implement their local evaluations. The strong local Program ownership resulted in similar projects being developed, implemented and evaluated in different ways, adding to the complexity of the broader evaluation.

The Program's underlying premise was focused on incremental change and continuous improvement. In response to this, some initiatives explicitly used the PDSA quality improvement cycle (plan, do, study, act) to effectively demonstrate discrete improvements over time.

Ongoing incremental evaluation informs progress and enables initiatives to be fine tuned or modified in response to evaluation findings.

In other consortia, project development was clearly informed by an action learning model. For example, the development of the comprehensive psychosocial assessment tool described in Case Study 1 arose from the evaluation of earlier work strengthening breast care nurse practice.

However, on reflection, some evaluations appeared to be a once-off event—undertaken either in an early pilot phase or at the end of the overall Program.

For information on using the PDSA cycle to improve multidisciplinary care, see the document *Multidisciplinary care—improving patient outcomes*, another resource in this learning series.

More explicit articulation of the linkages between projects may have facilitated a stronger sense of project connection and of the underlying action learning or quality improvement cycles. Other initiatives may have benefited from more incremental approaches to evaluation. However, tensions also existed between 'doing what needed to be done' and the evaluation imperative.

7.1.2 Factors influencing evaluation

The evaluation approach undertaken by individual consortia may have reflected the different value placed on evaluation, the stretching Program timeframes, a lack of clarity about reporting requirements, competing work priorities and the different interests and skills of Program staff.

Although it was relatively easy to evaluate local initiatives in terms of the uptake of change and consumer outcomes, greater local sensitivity was needed to openly identify specific local factors influencing this change; for example, the impact of differing levels of local leadership. While a statewide survey gleaned some of this evidence in a generic way, the Program was less able to identify clearly those local factors that influenced change in what context.

On reflection, the development and implementation of evaluation strategies may have required a more structured statewide approach at an earlier stage of the Program. This would have ensured the collection of statewide quantitative baseline data and ongoing ‘common’ data collection to inform key stakeholders on comparable initiatives, processes and progress. The development of a range of evaluation tools that facilitated both a more consistent collection of minimum data, as well as allowing for local variation, may have added additional strength to the Program evaluation.

In some respects, an outcome of the ‘innovative’ approach adopted to implement the Program, with its strong emphasis on local ownership, local issues, local initiatives and minimal central directives, may have constrained the ability of consortia to jointly implement and evaluate similar strategies.

A more structured and earlier statewide approach to evaluation may facilitate the collection of a consistent minimum data collection across complex programs.

In spite of the challenges, the evaluation reflected many achievements and improved our understanding of the complexity of both implementing and evaluating organisational change. It also provided a greater understanding of those factors that influenced sustainability and spread.

7.2 Sustainability and spread

Across all nine consortia a range of initiatives were made sustainable within individual services and across services. A benefit of the consortia was that they facilitated the spread of change across services.

A number of initiatives developed in one consortium were also adopted by others. This spread happened in a more ad hoc or informal way. Examples of sustainability and spread included:

- the utilisation of an audit tool to review the functioning of multidisciplinary team meetings
- the adaptation of the multidisciplinary meeting model to facilitate the management of women with advanced breast cancer
- the uptake of psychosocial assessment processes across consortia.

A number of factors influenced sustainability and spread.

To optimise success and sustainability, service improvements need to have demonstrated benefit for and involvement of consumers and service providers.

For information on the young women's project, see the document *Building partnerships with consumers for improved service delivery*, and for patient-held records and GP teleconferencing, see *Continuity and coordination of care—improving the 'cancer journey'* other resources in this learning series.

7.2.1 Perceived benefit to consumers and stakeholders

Initiatives that had both benefit for consumers or other service providers (for example, general practitioners) *and* clinicians had the greatest likelihood of being maintained. For example, once established, multidisciplinary meetings were perceived not only to have benefits for patient management, but also as being beneficial to individual service providers and the team.

Consumer-oriented projects or innovations that required changes in clinical practice were more likely to be successful and maintained when developed with consumer and clinician input. The patient-held records in two consortia developed with strong clinician and consumer involvement were the most successfully maintained and highly valued by both groups.

A young women's project developed with very strong consumer involvement resulted in a range of initiatives, some of which required changes in clinician practice. On reflection, much stronger clinician engagement was needed earlier in the project to facilitate greater clinician ownership of the change and enhance sustainability.

Innovations that were too labour intensive for service providers were less likely to be sustained. For example, the use of teleconferencing with general practitioners was only maintained fully in one of the four trial sites. Strong clinical leadership facilitated the sustained practice.

7.2.2 Embedding change into practice and culture

Sustainability and spread were optimised when roles and responsibilities were built into routine structures and practices. For example, in some consortia Program staff played a key role in establishing and organising the multidisciplinary team meetings. Over time, these roles and responsibilities were taken up within the roles of ongoing staff members.

Sustainability was further strengthened—but less easily measured—when practices were subtly embedded into the culture of 'the way we do things around here'. For example, multidisciplinary review meetings across Victorian breast services and the introduction of formal and early psychosocial assessment of women in some services have become the norm of practice.

Importantly, sustainability also included incorporating the commitment to continuous quality improvement into the mindsets and roles of stakeholders within services. After the completion of the Program, at least one service has established an ongoing strategic planning and service improvement strategy.

Finally, sustainability was enhanced through the implementation of professional skills development and training opportunities. These initiatives strengthened the knowledge, skills, capacity and confidence of service providers to adopt and sustain new practices. The continuation of some breast care nurse networks, and the ongoing availability of orientation packages for future junior medical staff, maintains and enhances the spread of Program initiatives.

To maximise sustainability, new roles and responsibilities must be embedded in the routine structures and practices and become part of the 'way we do things around here'.

However, within some consortia, sustainability of current improvements, and the capacity to maintain the momentum of future service improvements, were clearly constrained by the withdrawal of staffing resources at the end of the Program. In a small number of cases, the continuing Program extensions gave key stakeholders a false sense of security that it would not end. This perceived expectation that the Program would be continued, constrained attempts to embed practices into routine roles.

7.2.3 Time and resources

All organisational change requires time. The extended timelines of the Program effectively facilitated the trial, review, adaptation and spread of many initiatives.

For some projects, significant time and energy was invested in developing an innovative product. The availability of products (such as new information resources on service intranets or the Internet as downloadable files) has resulted in sustainable access to these resources.

At times, the development of a product (such as an information resource or a community consultation) was perceived by some stakeholders as an end in itself. This may have limited the team's or organisation's commitment to the next stage in implementation or change.

On reflection, as much—if not more—energy and time was needed to ensure the effective uptake of innovative products into practice and, if successful, sustainability.

Sustainable change was most successful when there was:

- ✓ strong tailoring of implementation strategies to match local barriers
- ✓ use of multiple, rather than single, approaches to reinforce change
- ✓ use of a strong evidence base to inform implementation strategies
- ✓ a focus on a smaller number of projects, reducing the dilution effect of multiple projects
- ✓ less ambitious and more realistic goals implemented within the timeframe
- ✓ a more active focus on spreading effective initiatives across consortia.

However, the need for a stronger focus on effective implementation and sustainability conflicts with the strong local and central drive for continuous innovation. Sustaining the interest and momentum of all stakeholders in the 'long march of change' remains a significant challenge.

7.2.4 Achieving ongoing funding

From their commencement, consortia were encouraged to use the incentive funding to develop sustainable projects that would not require ongoing resources. However, the funding of some initiatives on a trial basis was fundamental to gaining 'local buy-in' to achieve service redevelopment.

Achieving ongoing funding was particularly challenging for some initiatives that were initially funded within pilot projects, including some breast care nurse positions and newly established specialist services. Some consortia successfully developed strong business cases for the funding of new breast care nurse positions, or negotiated increased BCN hours through the relevant managers or executives.

Factors influencing the successful negotiation of new or increased funding included:

- ✓ articulation of best practice evidence
- ✓ the alignment of the initiative with corporate goals
- ✓ gaining support from a range of executive stakeholders and consumers.

Gaining ongoing funding for some service initiatives (such as a lymphoedema clinic) also required some tailoring of the core service elements to best match the available funding.

In some consortia, local services' commitment to ongoing funding once the pilot project had successfully demonstrated clear outcomes did not translate into resources when needed. Continuing budget deficits within health services presented a major barrier. More formal cost-benefit analyses of some initiatives may have provided a stronger argument for ongoing funding in some services.

Even with local executive support, it was clear early on that some services were going to struggle to access the funding needed to continue services. This was further constrained by the Program's focus on only one area of cancer service delivery.

At a department level, the development of a strategic purchasing policy was an identified initiative within the Breast Disease Service Redevelopment Strategy.¹ Achieving this to support increased health service funding was very difficult. The capacity of the Coordination Unit to align initiatives with existing Department of Human Services funding mechanisms, or to work towards establishing new funding mechanisms, was also constrained by breast cancer being a small program area in a broader funding model.

At times, an impasse about ongoing funding occurred between some local Program staff, health service executives and the Department of Human Services. It resulted in high levels of anxiety for role incumbents uncertain of their future, as well as cynicism amongst other stakeholders.

The resolution of funding issues for breast care nurses within one service took considerable time, ongoing dialogue with service executives and continuing encouragement from the Coordination Unit. The identification of local efficiencies not previously realised provided a final but unexpected trigger to facilitate funding. The identification of these efficiencies may assist in a cost-benefit analysis and the development of successful business cases in the future.

Negotiating new funding resources locally or through broader central funding mechanisms was constrained by the Program's focus on only a small area of service delivery.

7.2.5 Enhanced coordination across consortia

The Program's strength was its encouragement of consortia to develop and implement ideas in response to local needs. The duplication of some initiatives across consortia was important, because it strengthened local ownership, improved understanding of the local factors that influenced change and provided common learnings across settings. However, the emphasis on local ownership may have limited the spread of successful initiatives.

As the Program time was extended and more initiatives were implemented, there was a stronger desire at both the Program and Coordination Unit levels to formally share knowledge, information and resources that would facilitate evaluation and learning across consortia. The Coordination Unit played an important role in supporting this learning. In addition, the communication and trust between Program staff enhanced the informal spread and adaptation of successful initiatives across some consortia.

On reflection, the spread of successful initiatives within consortia may have benefited from stronger local executive support as well as a more proactive and formally coordinated approach to spreading successful initiatives across consortia.

In the presence of limited local executive support, the role of the Coordination Unit was crucial in supporting Program staff as they endeavored to ensure consortia achievements were sustained for the future.

7.3 Learning from the past—informing the future

The achievements and learnings from the Breast Services Enhancement Program have been substantial, as reflected in all the resources within this learning series.

One key learning of supporting sustainable change has been the importance of embedding change management programs, such as the Breast Services Enhancement Program into the core business of health services. In addition, strong program evaluation is needed to capture both the successes and challenges to inform future service improvements.

Finally, to improve outcomes for health service consumers, the important bottom-up approach to organisational change must be matched with strong executive support within the health service as well as at the departmental level.

8 Resources and tools

Victorian Breast Services Enhancement Program resources

To access a range of project reports see www.health.vic.gov.au/cancer

Learning series resources

The following resources are also part of this learning series and are available on www.health.vic.gov.au/cancer:

- *Multidisciplinary care—improving consumer outcomes*
- *Continuity and coordination of care—improving the cancer journey*
- *Building partnerships with consumers for improved service delivery.*

NSW resources

The following resources have been identified as general guides for improving patient care services:

Easy Guide to Clinical Practice Improvement—A guide for health care professionals.

Available at: www.health.nsw.gov.au/quality/pub/cpi_easyguide.pdf

The Clinician's Toolkit for Improving Patient Care. Available at:

www.health.nsw.gov.au/health-public-affairs/publication/quality/toolkit.html

NHS Modernisation Improvement Leader Guides

As part of its extensive approach to improving the National Health Service in the UK, the NHS Modernisation Agency have produced an excellent range of guides which provide practical advice to support change within health services.

These guides are all available at:

www.modern.nhs.uk/improvementguides/culture/9.htm

The guides cover the following range of topics:

Series 1:

Process mapping, analysis and redesign

Matching capacity and demand

Measurement for improvement

Series 2:

Involving patients and carers

Managing the human dimensions of change

Spread and sustainability

Series 3:

Building and nurturing an improvement culture

Working in groups

Redesigning roles

Working with systems

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