# Guide to developing your regional palliative care plan

Palliative Care Consortia–November 2004

Victoria
The Place To Be

# Guide to developing your regional palliative care plan

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# 1. Introduction

The Continuing Care Unit, Programs Branch, Department of Human Services has developed this document to assist regional palliative care consortia to develop regional plans for the period 2004–09.

The document has the following sections:

- setting the scene: provides the context of the regional consortia, an overview of regional plan requirements, and the priority principles
- resources: those required or available to support regional planning
- developing the plan: includes data gathering, setting priorities and strategies, and finalising the plan
- managing the process: engaging stakeholders and consumers, critical success factors
- tools: this includes data gathering tools, 'process' tools, and the regional plan template.

# 2. Setting the scene

*Strengthening palliative care: a policy for health and community care providers 2004-09* (the *Strengthening palliative care policy)* provides us with exciting directions for improving access to appropriate palliative care services for people with life-threatening illness and their families across Victoria. The policy is about new ways of working together, between the Department of Human Services and regional or local services and between local hospitals and community services. It also allows an opportunity to link in with other initiatives, such as the Integrated Cancer Services Program and Primary Care Partnerships.

As with any new initiative, the policy implementation will be challenging and the section, 'Managing the process' addresses these challenges in a little more detail. However, there are no magic solutions; we will be breaking new ground and learning together. What works well in one region, might be less successful in others. We will learn as much from the challenges as from the successes.

At a local and regional level, you will know most about your services. The Department of Human Services recognises the strengths of palliative care services across Victoria and your commitment to improving care for people facing life-threatening illness and their families. We also know there is variability in how services currently work together across sectors or a region. For some regions, developing the consortia will be a formalisation or affirmation of current working structures and might bring some new stakeholders to the table. In other regions, it might be the first time services within a geographic region have formally worked together.

Some regions (or sub-regions) might already have a strategic plan in place which will need to be reviewed and adjusted to meet the priorities of the *Strengthening palliative care policy*. Others might have a good understanding of the regional service profile, but not a common view of service gaps and priorities. In other regions, there might be more limited understanding of the different service profiles within the region and the common gaps and priorities. So in developing regional plans, each regional consortium might be starting at a different place. This 'guide' has been developed to support you in developing this plan. Please dip into it in the way you wish.

The 'bottom line' for each region is the development of an agreed service plan for which a template is provided.

This document is being forwarded as a hard copy to each consortium and is available electronically on <www.health.vic.gov.au/palliativecare/>.

## 2.1 *Strengthening palliative care policy* – the vision

All Victorians with a progressive life-threatening illness and their families and carers will have access to a high quality service system which fosters innovation and provides coordinated care and support that is responsive to their needs.

## 2.2 The purpose of the regional palliative care plans

Each regional palliative care consortium will develop a plan for how palliative care services are to be delivered across their region. The plan will also detail how the consortium will work together with other health and community care providers to strengthen patients' access to the palliative approach and appropriate access to specialist services.

In particular, each regional palliative care plan will identify the priority palliative care needs of the local communities and describe how the consortium is working together with meaningful input from people with life-threatening illnesses, families and carers.

The regional palliative care plan should:

- be simple, practical and regionally focused
- be forward looking
- support and drive *Strengthening palliative care: a policy for health and community care providers 2004–09*, outlining regional priorities and what agencies will do to achieve these
- complement existing planning frameworks, such as the Primary Care Partnerships, the Integrated Cancer Services Framework, Home and Community Care and other relevant service frameworks.

## 2.3 Template for 2004–09 regional palliative care plan

The regional palliative care plan template is included in section 8, 'Tools and templates' and aims to:

- encourage plans that are concise, simple to read, easy to navigate and relevant to the community and consortium members
- balance core statewide requirements with regional relevance and flexibility for local variation
- closely link with departmental regional and program policy, planning and funding
- focus on both describing service system development and implementation strategies and identifying their impacts or outcomes for people with a life-threatening illness, their families and carers, and the community.

The plan must be consistent with the seven principles set out in *Strengthening palliative care policy (*see Box 1) and must specifically address the priority principles. The priority principles (principles 3, 4 and 5) focus on improving access to the palliative approach and specialist palliative care services and on strengthening coordination and integration of care.

**Box 1: Strengthening palliative care policy principles**

1. People with a life-threatening illness and their carers and families have information about options for their future care and are actively involved in those decisions in the way they wish.
2. Carers of people with a life-threatening illness are supported by health and community care providers.
3. **People with a life-threatening illness and their carers and families have care that is underpinned by the palliative approach.**
4. **People with a life-threatening illness and their carers and families have access to specialist palliative care services when required.**
5. **People with a life-threatening illness and their carers and families have treatment and care that is coordinated and integrated across all settings.**
6. People with a life-threatening illness and their carers and families have access to quality services and skilled staff to meet their needs.
7. People with a life-threatening illness and their carers and families are supported by their communities.

There are four key components to be addressed within your regional plan:

1. the methodology or approach
2. the regional context
3. gaps and priorities
4. addressing the priorities – the strategic plan.

Table 1 summarises the key content to be included in the regional plan.

**Table 1: Overview of regional palliative care plans**

<table>
<tr><th>Section</th><th>Content</th></tr>
<tr><td>Methodology or approach</td><td>This section should provide a brief overview of the methodology or process used to develop the plan.</td></tr>
<tr><td>The regional context</td><td>This section should briefly describe the context in which the 2004–09 regional palliative care plan is developed. This should include:<ul><li>a very brief overview of the region and demographics</li><li>current palliative care services within the inpatient and community services, including any inreach and outreach services</li><li>a profile of other relevant services, such as access to Home and Community Care and respite</li><li>current arrangements between hospitals and specialist palliative care services to ensure all hospitals have access to the full range of specialist palliative care services required for people with a life-threatening illness and their carers and families</li><li>any current arrangements to link all specialist hospital and community palliative care services with an acute care facility which can respond to the acute medical care needs of the patient (such as a bowel obstruction, a bone fracture or a cord compression)</li><li>arrangements to link all specialist hospital and community palliative care services with a facility that can respond to significant psychological or psychiatric needs of the patient</li><li>links between palliative care and general service providers.</li></ul></td></tr>
<tr><td>Gaps and priorities</td><td>This section identifies gaps in service provision and determines priorities.</td></tr>
<tr><td>Addressing the priorities – the strategic plan</td><td>This section must address the identified priorities and will include:<ul><li>the overall vision for the consortium and a set of shared values that reflect the principles</li><li>strategies describing how the providers in the consortium will work together and with other key stakeholders to address and implement service development priorities</li><li>how the consortium will facilitate the appropriate hospital role designations in accordance with the agreed criteria, and ways in which it will address any gaps in levels of service within a region</li><li>mechanisms to facilitate the integration and efficiency of service delivery</li><li>mechanisms to help coordinate patient care across care settings</li><li>timelines and resources.</li></ul></td></tr>
</table>

## 2.4 Support for development of regional palliative care plans

You can direct enquiries about the development of your regional plan to the following officers.

| Region | Departmental regional contact | Departmental central office contact |
|---|---|---|
| Barwon South Western | Anne Fairbairn<br>5226 4661<br>anne.fairbairn@dhs.vic.gov.au | Vivien Adler<br>9616 1334<br>vivien.adler@dhs.vic.gov.au |
| Grampians | John Koopmans<br>5333 6020<br>john.koopmans@dhs.vic.gov.au | Michael Bramwell<br>9616 2114<br>michael.bramwell@dhs.vic.gov au |
| Loddon Mallee | Colin Wellard<br>5434 5527<br>colin.wellard@dhs.vic.gov.au | Amanda Bolleter<br>9616 2115<br>amanda.bolleter@dhs.vic.gov.au |
| Hume | Janine Holland<br>5722 0923<br>janine.holland@dhs.vic.gov.au | Michael Bramwell<br>9616 2114<br>michael.bramwell@dhs.vic.gov au |
| Gippsland | Laurice Ryan<br>5177 2566<br>laurice.ryan@dhs.vic.gov.au | Michael Bramwell<br>9616 2114<br>michael.bramwell@dhs.vic.gov au |
| North and Western Metropolitan | Sarah Lacey | Michael Bramwell<br>9616 2114<br>michael.bramwell@dhs.vic.gov au |
| Eastern Metropolitan | David Hampton | Vivien Adler<br>9616 1334<br>vivien.adler@dhs.vic.gov.au |
| Southern Metropolitan | Liz Jones | Amanda Bolleter<br>9616 2115<br>amanda.bolleter@dhs.vic.gov.au |

**Please note the first port of call for the five regional palliative care consortia is the department's local regional office. Metropolitan services should contact the relevant person within central office.**

Once consortia are developed, regular statewide meetings will be held to support the development and implementation of the regional palliative care plans.

## 2.5 Submission of regional palliative care plans

### Interim plans

Each consortium should submit an interim plan to the Department of Human Services by **29 April 2005**. For rural regional consortia, the plan should be forwarded via the regional office. Metropolitan services should submit their plans directly to the central office (see below).

The interim plan should outline the key findings from the initial data gathering and consultation, the agreed priorities and an overview of the proposed strategies. This plan will enable discussion of the plan and some initial feedback to each consortium.

### Final plans

Each consortium will submit one hard, unbound copy and one electronic copy (either on CD or via email) of the **final plan** by **close of business 30 June 2005**.

Regional consortia should submit their plans to the regional director at the relevant regional office. Regional offices will forward copies of all regional palliative care plans to the department's Palliative Care Program in the central office.

Metropolitan consortia should submit their regional plans directly to:

Vivien Adler
Manager, Palliative Care and Specialist Programs
Department of Human Services
10/589 Collins Street
Melbourne VIC 3000

Email: vivien.adler@dhs.vic.gov.au

## 2.6 Overview of timeline

| Action | Timeline |
|---|---|
| Bringing together of consortia | November 2004 – January 2005 |
| Memorandum of understanding signed by all parties | By end of January 2005 |
| Submission of interim plan | By Friday 29 April 2005 |
| Feedback on plan | By Friday 20 May 2005 |
| Submission of final plan | June 30 2005 |
| Any final adjustments to plan | As agreed |
| Payment of 2005 funds | On sign-off of final plan |

## 3. Resources

Each consortium is being provided with funding to support the development and implementation of the regional palliative care plans (see budget guide in the draft memorandum of understanding). Depending on the current resources within each region, you might need to allocate at least some of the funds to support the service planning and possibly some of the implementation strategies. This might be through:

- employing an external consultant to undertake specific aspects of the service planning
- employing a short term staff member to develop your regional plan
- employing a regional coordinator to support the development and implementation of the regional plans until June 2006.

In allocating your funds there is a need to try to strike a balance between funding additional resources to help develop your plan and supporting implementation initiatives (for example, developing protocols across services), and putting funds towards meeting direct service delivery gaps (for example, strengthening an inreach service). While it might seem optimal to put all the funds into meeting direct service delivery gaps, some other service improvement strategies, such as developing and implementing referral protocols and facilitating role designation, might not be easily achieved unless some resources are available to support them.

Finally, a number of tools have been developed to assist you in developing your regional plans. The tools are referred to in the relevant sections of this document and are all listed in section 8. Each tool is included in the attachments to this document.

**Useful tips**

- Explore what other resources are available to support your regional planning through the consortia partners or other stakeholders. For instance, you might be able to access statistics, mailing lists and possibly some administrative support through your regional Department of Human Services office (especially in regional Victoria), local Primary Care Partnerships, and local Divisions of General Practice.
- Linking with the local Integrated Cancer Services might enable some sharing of resources and data and possibly some consultation processes. The regional Integrated Cancer Services parallel the regional palliative care consortia, however, there is some variation between the metropolitan Integrated Cancer Services and the Metropolitan consortia. (Austin Repatriation Medical Centre services link in with the Eastern Integrated Cancer Services, whereas palliative care services link in with the North and West Palliative Care Consortia, as per departmental regions).
- Use and adapt the tools to best meet your needs.

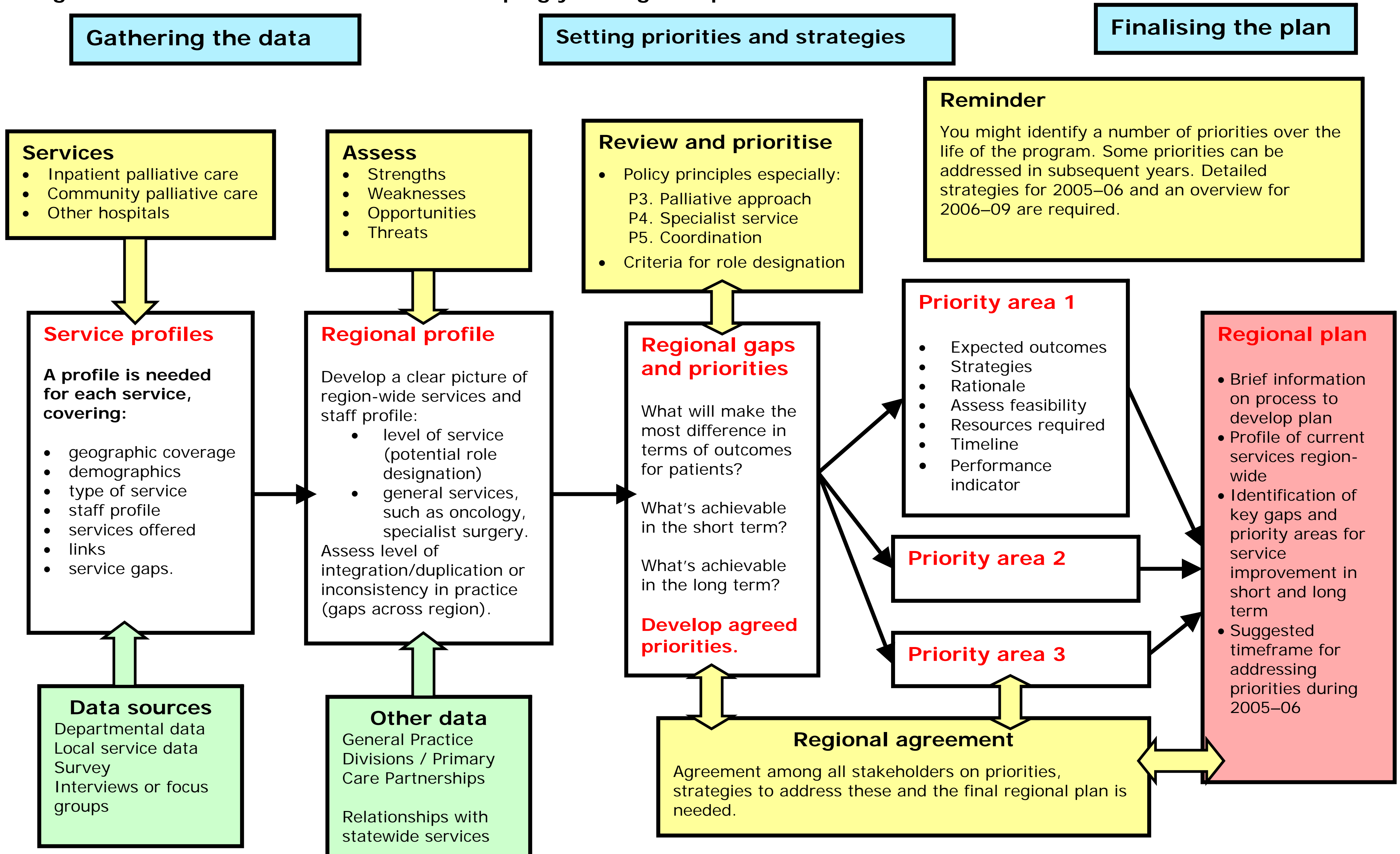
## 4. Developing the plan

There are three clear steps for developing your plan:

1. gathering the data
2. setting priorities and strategies
3. finalising the plan.

**Consultation with key stakeholders must inform all steps of the process**. Figure 1 provides a visual guide to the steps and some of the key processes.

**Figure 1: Palliative care consortia – developing your regional plan**



## 4.1 Gathering the data

Through this data gathering you will gain your regional profile, including:

- features of your geographic region and demographics
- a clear picture of region-wide palliative care services, including the staff profile and current relationships across local palliative care services
- the level of service provision across the region
- relevant acute, sub-acute and community services, such as oncology and specialist surgical services
- links and current referral mechanisms between palliative care services, and between palliative care services and:
  - oncology and other acute and sub-acute services
  - local general practitioners and General Practice Divisions
  - Primary Care Partnerships
  - statewide organisations
- an assessment of the level of integration, duplication or inconsistency
- current gaps across the region.

How well your region is connected and how much local or sub-regional data is readily available will determine your starting point. You might need to start by gathering data from each local service and then collating this into the regional profile.

**Useful tips**

- Be pragmatic in the selection of the information collected and analysed.
- Consider the resources available, time constraints and the ultimate application and usefulness of any data for analysis.
- Maintain a balance between accessing broad and specific data.
- Use data that are already available.
- If data are not available, prioritise what you need to collect.
- Gather and analyse your data through the 'lens' of different service providers and consumers.
- Identify significant data gaps which might need to be part of future initiatives.

### Data sources

Data can be gathered from multiple sources. Some quantitative data will be readily available to you through routine data sources. The Service and Workforce Planning Branch of the Department of Human Services will shortly be releasing a range of data at different geographic levels. We will let you know when these data become available.

This new data system will enable you to readily gain access to detailed demographic and other data for local service areas (collection districts, postal areas, statistical local areas, and local government areas). Some data will be made available on the Internet, while some might only be available on the department's Intranet. The departmental contacts might assist you in accessing these data.

Other data can be gathered through specific service mapping tools and through consultation with key informants via individual or group interviews. Key informants might include:

- local palliative care providers at both executive and service levels
- other service providers, for example, general practitioners, General Practice Divisions, community health, Primary Care Partnerships, local oncologists and other acute care providers
- consumers (patients and carers) and volunteers.

Table 2 summarises the types of data and possible sources.

### Table 2: Data sources

| Data | Sources |
|---|---|
| Profile of region | • Any current regional service plans (for example, Primary Care Partnerships), local government reports, Australian Bureau of Statistics information<br>• New data sources via Department of Human Services' Internet and Intranet sites (to be notified when available) |
| Profile of current service users | • Community services – Victorian Palliative Care Reporting System (Complete data are available at a service and regional level for 2003–04.)<br>• Hospital services – Victorian Admitted Episodes Dataset |
| Current services and staff profile | • Local palliative care services<br>• Other relevant service plans, reports, key informants |
| Service links | • Any local referral pathways and protocols<br>• Any current formal agreements between services<br>• Key informants |
| Local service gaps | • Key informants |

### Tools to assist data gathering

**Tool 1**: Service mapping tool
**Tool 2**: Regional service profile
**Tool 3**: Principles – key questions
**Tool 4**: Case study analysis

### A note about role designation

- A key component of the *Strengthening palliative care policy* is the role designation for palliative care services.
- Draft criteria have been established as part of the policy.
- In early 2005 the Palliative Care Unit will be working with key stakeholders to finalise these criteria. This will take some time. Once agreed, the criteria will be made available to the consortia.
- In some consortia there might be gaps in a level of service; for example, no service might meet all the criteria for a Level Three service. In this instance, how to achieve a Level Three service might be built into the regional service plan.
- Having a good understanding of the profile of the services within your region is good preparation for the role designation work.

## 4.2 Identifying gaps and determining priorities

Through your data analysis, you will gain a good perspective on palliative care services and other relevant services (such as Home and Community Care and respite) across the region. From the data you should be able to identify some of the key strengths, weaknesses, gaps and opportunities for service improvement. You might want to do this with all consortium members formally participating in a regional SWOT (strengths, weaknesses, opportunities and threats) analysis (see Tool 5). This might assist members to:

- gain an improved understanding of the regional service profile
- gain a shared understanding of common and differing perspectives
- strengthen regional collaboration and ownership.

Important outcomes of this process will be the identification of:

- similarities and variations in practice across the region
- innovative or 'good practice' initiatives within services
- opportunities that might enhance initiatives within your region
- weaknesses or service gaps (these might be focused in one area or service or be common across services).

From your list of service gaps, however long or short, the consortium needs to identify key priorities based on agreed criteria. These criteria might include:

- What will make the most difference in terms of patient outcomes?
- What is achievable in the short term and within current resources?
- What is achievable in the long term? What level of resources will be needed to achieve a long term strategy? (Do you need more time to achieve the outcomes? Are strategies dependent on additional resources?)
- What are effective or innovative strategies to address the priority within a service and provide a basis for 'easy' adoption?
- Does the rationale for each priority fit into the priority principles of the *Strengthening palliative care policy?* If it is outside these priority principles, can you make a strong argument for why it is a priority in the short term?

**Please note** the agreed regional priorities (in line with policy) should drive the resource allocation rather than the activities and funding being spread evenly across a region.

**Useful tips**

- Consider gaining advanced agreement from consortium members on the assessment criteria against which they will identify priority service gaps.
- If achieving agreement on priority gaps is difficult among consortium members or if you are concerned the 'squeakiest or largest wheel' will 'win' the day, ask members to vote on their top three priorities (for example, by giving three points to the first priority, two points to the second, and one point to the third priority).
- An alternative for developing your priorities is to use Tool 6, 'Developing priorities – consensus tool' in which all participants nominate their three priorities with the rationales and then all participants vote on their top ten priorities.
- The early development of regional protocols and referral pathways and the facilitation of service role designation are clearly articulated as key priorities within the *Strengthening palliative care policy*.

For your service plan, you need to clearly identify:

**Category 1**: priorities for immediate action – to be achieved by June 2006
**Category 2**: priorities for future action once the first priorities are achieved
**Category 3**: priorities that will require additional funds to achieve. These priorities will inform the department of any future funding bids (see below).

### Tools for assessing gaps and priorities

**Tool 5**: SWOT analysis
**Tool 6**: Developing priorities – consensus tool

## 4.3 Developing strategies

Once you have identified your agreed priorities you need to develop strategies to address them. The evidence indicates that in a change management process a multifaceted approach is more likely to be needed to optimise success (Nutley & Davies 2000).

Each service plan must clearly articulate the detailed strategies to address the Category 1 priorities and those needed to progress Category 2 priorities by June 2006. In addition, for any Category 3 priorities, you will need to articulate how you think this priority area can be addressed in the future. This should include the rationale, suggested strategies and an indicative budget. This information will inform future bids for funding within the department; however, services should **not** build-up unrealistic expectations. **Remember** any palliative care funding bid has to compete against a wide range of other funding proposals and government priorities.

**Useful tips**

- Doing a 'program logic' (see Tool 7) can help you develop your strategies or clarify their robustness and capacity to achieve your goals.
- Figure 1, 'Developing your regional plan', is an example of a 'program logic'.
- In developing your strategies, consider any opportunities to develop joint strategies with other Department of Human Services initiatives; for example, working with your local Integrated Cancer Services regional plan to strengthen communication and referral between oncology and palliative care services.

Table 3 outlines a structure for developing your strategies.

**Table 3: Developing strategies**

| | Factors to consider and address |
|---|---|
| **Problem definition**<br>What is the problem or service gap? | • What are your goals?<br>• What are the objectives? (Check they are SMART: **s**pecific, **m**easurable, **a**chievable, **r**ealistic and **t**imely.)<br>• Who is the target audience? |
| **Solution generation**<br>What changes in practices, processes, protocols and systems are needed to meet the objectives? | • Use evidence-based practice and good practice models.<br>• Identify any relevant regional action.<br>• Identify the appropriate mix of interventions.<br>• Identify the activities required, including opportunities and barriers that will influence implementation and approaches to address these as needed. |
| **Support and resources**<br>What will you need to achieve this? | • Identify the roles and responsibilities of the key stakeholders, including who will implement and monitor each activity.<br>• Assess and allocate appropriate resources.<br>• Identify opportunities and barriers.<br>• Identify key capacity building strategies required to ensure success (including workforce development).<br>• Identify proposed timelines for each activity. |
| **Review and evaluation**<br>How will you measure your success? | • Consider process, impact and outcome indicators.<br>• How will you measure unexpected outcomes?<br>• What key performance indicators can you establish?<br>• How will you and when do you expect to be able to measure patient outcomes? |

## 4.4 Finalising the plan

Use the regional palliative care plan template (see section 8) to bring all the information together. Ensure you gain agreement to the plan from all key stakeholders.

**Tools to help develop your strategies and finalise your plan**

**Tool 7**: Assessing your regional plan – developing a program logic

## 4.5 Gaining sign-off

The service plan needs to clearly indicate all key stakeholders' endorsement. In addition, sign-off by the chief executive officers of all participating services is required when:

- an agency is represented by another person on the consortium
- an agency is not represented on the consortium, but will be impacted by the plan or their involvement is crucial to the successful implementation of the plan.

# 5. Final approval

Staff of the Palliative Care Program within the department's central office and regional office staff will review service plans. The service plans will be reviewed by the following criteria:

- **clear articulation of current service gaps and priorities**
- **degree to which the priority principles are addressed**
- **clarity of aims and timelines of strategies to address priority gaps**
- **clarity, definition and rigour of methodology**. This includes a risk analysis identifying opportunities and barriers to successful implementation and completion of the plan. The risk analysis must outline strategies to harness the opportunities and to overcome the identified barriers. Plans should identify how strategies link together and how they might link with other systems, projects or initiatives, such as the local Integrated Cancer Service and Primary Care Partnerships
- **mechanisms for ongoing key stakeholder contribution and support**. Plans should clearly articulate how key stakeholders will be involved in developing, implementing and evaluating the plan or specific strategies within it
- **a clearly defined evaluation approach, including performance measures**
- **timeframe, milestones and budget**. Key milestones must be identified within a reasonable timeframe and within the established budget. Budgets should identify staffing, operating and infrastructure costs
- **sustainability**. Any specific strategies and outcomes that might not be sustainable without additional resources in the future should be identified along with possible mechanisms to address this at the local level; for example, embedding ownership in target groups and key stakeholders, and any ongoing financial commitment.

## 5.1 Peer review

It is hoped that through the implementation of the *Strengthening palliative care policy* collaboration between regional consortia and between services within a region will be strengthened. To encourage this collaboration in a positive way, consortia might find it valuable to develop a 'peer review' process to contribute to the review of the regional palliative care plans. Such a process might assist in stimulating and sharing ideas and cross-consortia collaborations. The interest in this and the possible processes to be used will be discussed with the consortia once developed.

# 6. Funding requirements

Following approval of regional plans, each consortium will be required to provide:

a. a final regional plan incorporating any final adjustments that might arise following the department's review and as agreed with the consortium

b. reports on negotiated dates that should:

- describe progress to date, including any variations to the timelines, approaches and processes
- outline achievements
- measure ongoing performance against milestones as agreed
- identify expected and unexpected outcomes
- identify key learnings
- address how initiatives might be broadly applied across the palliative care sector

c. presentations on regional plan initiatives at forums as negotiated with departmental staff.

# 7. Managing the process

## 7.1 Stakeholders

Each consortium will bring together multiple stakeholders, all with their own sets of values, priorities and issues. Within each stakeholder service, there will be a range of other key players who will be important to bring on side to achieve the agreed improvements in care.

While different stakeholders might hold a range of different values, the consortium's objective is to make bridges between these positions to enhance local ownership and to embed change across the system. Developing and articulating a common purpose and vision might do much to build this bridge.

A wide range of formal and informal communication strategies for all stakeholders might be needed to:

- communicate the purpose and vision of the regional palliative care plan
- elicit people's concerns and support
- maximise local ownership
- communicate the small wins
- identify expected and unexpected opportunities that might optimise the achievement of goals.

Working with and engaging the stakeholder is perhaps the most critical component of any change management initiative.

## 7.2 Engaging with consumers

There is increasing emphasis on consumer participation in health policy and service development and implementation. This is a challenging area for all health services and might even be more so for palliative care services, given the nature of palliative care clients. Consumers of course can be both the patients and their carers.

You need to consider how you will involve consumers in your program development in a meaningful and not 'tokenistic' way. Starting points might be:

- linking in with any local service consumer reference groups
- volunteers who have come to volunteering from a carer experience and who might have useful experience. Their feedback, however, might be coloured by their volunteer experience or by the distance they are from their caring experience or they might not have up-to-date information about your local services
- data from either local consumer or carer surveys or the more recent Victorian Carer Satisfaction Surveys.

Other options could include:

- involving consumers in your advisory group (remember, two consumer representatives is better than one to give each other support)
- developing a consumer reference group
- holding a 'focus group' with people who are attending a day hospice program
- undertaking a small number of critical informant interviews, which might give you much information
- teleconferencing, which might be a way you can bring patients together in a focus group.

## 7.3 Statewide specialist services

There are a number of statewide services that provide specialist consultation and services to people within particular groups. These services, which are relatively small, support people with motor neurone disease, HIV–AIDS and children with life-threatening illnesses across Victoria.

In developing your regional plan you need to address how services currently link in with and use these specialist services and how you will do so in the future. To facilitate communication between statewide and local services, the statewide services will participate in the regular meetings between the department and consortia members (see section 2.4). The statewide services are also keen to look at other ways they can work with you in developing and implementing your regional plans in the most resource-effective way.

The statewide services and contact details are listed below.

| Statewide service | Contact | Details |
| --- | --- | --- |
| HIV–AIDS Consultancy | Olga Vujovic<br>Infectious Diseases Physician | 9276 3658<br>o.vujovic@alfred.org.au |
| Motor Neurone Disease Association of Victoria | Rod Harris<br>Chief Executive Officer | 9830 2122<br>rharris@mnd.asn.au |
| Victorian Paediatric Palliative Care Consultancy | Carol Quayle<br>Manager | 9345 5374<br>9345 5522 (page)<br>carol.quayle@rch.org.au |
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## 7.4 Managing change and critical success factors

There is a plethora of literature (and 101 theories!) on change management and those factors influencing change processes. Kotter (1995) identifies an eight-step model for implementing change as indicated below.

| Step | Description |
| --- | --- |
| **Forming a powerful guiding coalition** | This involves moulding a group of individuals into an effective team and providing them with enough power to lead the change effort. |
| **Creating a vision** | A clear sense of direction is needed for all involved in the change process. |
| **Communicating the vision** | The vision needs to be communicated synergistically to all stakeholders. |
| **Empowering others to act on the vision** | Structures and processes need to be established to support change and to remove potential barriers. |

| Step | Description |
|---|---|
| | |
| **Planning and creating short term wins** | Early tangible signs of improvement provide momentum to continue. Success should be celebrated. |
| **Consolidating improvements** | Change needs to be incorporated into the fabric of the organisation and should be both person-centred and ensure adequate organisational support. |
| **Institutionalising new approaches** | Improvements should be integrated into routine practice to ensure the improvements and outcomes are maintained. |

Of course, the process is not linear and has many complex factors influencing it. The complexity of the health sector system adds to the challenge. Perhaps the key messages from the change literature, particularly in the health arena, are that:

- Multifaceted interventions might work better than single interventions.
- Different interventions work in different situations, depending on the context.
- There is no one approach that is effective for all changes in all situations (Grol & Grimshaw 2003).

Other critical success factors to consider include:

- A balance between top-down and bottom-up (push and pull) approaches works best, with bottom-up approaches being optimal to achieving local ownership.
- Take a systems approach to change. Change at a macro level (for example, organisational policies, development of guidelines) and change at a micro level (for example, targeted at changing individual practices) might be less successful unless the organisational practices or systems (for example, organisational cultures, embedded routines) are addressed and redesigned.
- Both clinical and executive leadership is essential.
- Local clinical champions need the authority to optimise change.
- Adequate resources are needed to support the change process.
- Start small and build on your achievements.
- Allow enough time for the required cultural change. This is always a challenge if working within a competing culture of the 'quick fix'.

### Useful references


Grol & Grimshaw, 2003, 'From best evidence to best practice: effective implementation of change in patients' care', *Lancet*, vol. 362, pp. 1225–30.

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# 8. Tools and templates

A number of tools and a template have been developed to assist you in developing your service plan. The tools listed below and attached support data gathering, priority setting, and documentation.

| Area | Tool | Descriptor |
|---|---|---|
| **Data gathering** | Tool 1 | Service mapping tool |
| | Tool 2 | Regional service profile |
| | Tool 3 | Principles – key questions |
| | Tool 4 | Case study analysis |
| **Priority setting** | Tool 5 | SWOT analysis |
| | Tool 6 | Developing priorities – consensus tool |
| **Developing strategies** | Tool 7 | Assessing your regional plan – developing a program logic |
| **Documentation** | Tool 8 | Regional plan template |

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