



HEAD OFFICE
ABN: 65 065 815 803

PO Box 995 LEETON NSW 2705
Phone: 02 6953 6454
Facsimile: 02 6953 6653

GRIFFITH OFFICE
PO Box 1067 GRIFFITH NSW 2680
Phone: 02 6962 7599
Facsimile: 02 6962 7499

Email: mdgp@mdgp.net.au
www.mdgp.net.au

Sustainability Decision Tool

Discussion Paper

Prepared by Ian Hatton

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Sustainability

This paper addresses the issue of sustainability not only within the Rural Palliative Care Program but also within the general health sector. It is intended as a starting place for those wishing to explore this complex and varied topic. The paper explores some of the research in developing and implementing organisational changes with the aim to continuously improve efficiency and effectiveness through a cycle of quality improvement. It includes suggestions on how to both demonstrate the potential or actual benefits of an improvement and the need for utilisation of available diagnostic tools as useful predictors of sustainability. Identifying weaknesses and opportunities for improvement.

The Griffith Area Palliative Care Service (GAPS) model the fore runner of the Rural Palliative Care program identified several key process elements in its success.

A more coordinated and integrated application of existing resources, requiring formal commitment from multiple key agencies, providers and community representatives to the objectives of the project, and

An investment in new resources. A major component of this investment was in the development of tools that will not require enhancement to recurrent funding (e.g. integrated patient-centred records, clinical guidelines, GP on-call roster, case review meetings, information system implementation and external evaluation). A relatively minor component is related to enhancement of recurrent funding where identified gaps in service delivery fell significantly short of national standards (eg, RN on-call roster, 1800 phone line, assorted variable goods and services linked to increased activity).

Sustainability was critical to success and four years after federal seeding funding ceased the project is still achieving its specified aims and objectives. This is not always the case for short term projects, It is generally accepted that one of the primary reasons why quality improvement and specific projects are difficult to integrate into an organisation is that many of the changes that are put into place fail to survive. Within the literature there is evidence of a high failure rate, up to 70%, of organisational change (Daft and Noe, 2000. Beer and Nohria 2001).

A short definition of sustainability can be described as 'when new ways of working and improved outcomes become the norm'. A more detailed version which includes the notion of 'steady state' in addition to promoting the desirability of continued improvement: "Not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed in support. In other words it has become and integrated or mainstream way of working rather than something 'added on'. As a result, when you look at the process or outcome one year from now or longer; you can see that at a minimum it has not reverted to the old way or old level of performance. Further, it has been able to withstand challenge and variation; it has evolved alongside other changes in the context and perhaps has continued to improve over time. Sustainability means holding the gains and evolving as required, definitely not going back" (NHS Institute for Innovation and Improvement 2005)

All change initiatives work within an anticipated time frame and have specific goals and objectives. The Rural palliative Care Program (RPC) was funded over a three year period with the aim to build upon the evidence of success and effectiveness of the Griffith Area Palliative Care Service (GAPS) Pilot Project developed and implemented by the Murrumbidgee Division of General Practice. The Department of Health and Ageing contracted the Australian Divisions of General Practice to manage an initial first phase of the Rural Palliative Care Program (the Program). The program is implementing models of care that translates the National Palliative Care Strategy into integrated services that work for rural Australia. It seeks to demonstrate that enhanced access to an integrated palliative care service for terminally ill people, their carers and families is achievable and sustainable within a rural context. The Program aims to extend the Griffith Area Palliative Care

service pilot model to other settings over a three-year period, and use what has been learned to date to guide implementation

The objectives of the project are ambitious because they imply that the model being tested is both sustainable in the long term and generalisable to other rural settings. The questions about whether these objectives can in fact be met, and whether the answers presented at the end of the project are likely to be clear and well supported by data, are the present focus of the evaluation.

A central principle to improvement efforts whether it be the RPC program or implementation another initiative is to shape services around the needs and preferences of patients and to continuously improve efficiency and effectiveness through a cycle of quality improvement. The focus on improving the patient's experience of and journey through care is essential. The sustainability of a change will be greatly enhanced if, in addition to this, the staff can also recognise a benefit in their own role which may manifest in certain tasks becoming easier or that their role feels more rewarding. The likelihood of sustaining the change is reduced if jobs become harder, processes are less efficient or work flow becomes more complex. Even if the reality is that none of this happens it may be perceived to do so.

It is well recognised that some changes may feel emotionally, physically or intellectually overwhelming to staff. (Venkatesh, 2000, Covin and Kilmann, 1990). As a result of the improvement initiative there will be changes to roles, relationships and working practices of the staff involved. It is essential that this is included as an important area within the project plan and thinking. In order to really understand the impact of the changes to roles it is essential that there is an understanding of what roles really look like before any changes take place.

One of the main reasons cited for hesitancy and resistance by staff is lack of involvement. Involvement can be defined as motivating, training, informing and enabling staff to contribute to the improvement process.

"Employees improve their performance through experiencing more control over and involvement in their work leading to an increase in personal commitment to management aims".
(Cunningham, Hyman and Baldry, 1996)

Meaningfully involving front-line health care staff is considered one of the biggest challenges facing health care organisations looking to make improvements.

The absence of involvement may be characterized by:

- a discouraged environment
- evident conflict between staff
- staff feeling disenfranchised, unappreciated and ignored
- low morale and high turnover
- lack of participation in meetings
- scepticism about the change.

There are a number of reasons that have been cited by staff who feel sceptical about change, these include;

- having insufficient information about the nature, purpose and significance of the change
- perceiving that the change has been a politically inspired, 'top down' initiative
- believing that there are other competing priorities that should take precedence
- feeling that the change has been presented in a way that is unfamiliar and irrelevant
- believing that the change will not be beneficial to staff, patients or the organisation
- fearing that the change will be threatening to individual power and status.

Process mapping has proven to be an important tool that helps staff to engage in the change process. Mapping helps to identify the work detail of the whole patient process and often illustrates areas of duplication, waste or inefficiency that staff are unaware of. Staff should be encouraged to create their own map which links into the patient process map that was prepared for the change. They should specifically describe their roles and responsibilities at each step of the way. Thi

provides a good visual display that can be updated as roles and processes change at each stage of the life of the project. An example can be made from the Southern Queensland RPC project who invested in mapping services against the palliative care national standards, this process was undertaken across multiple service providers with very positive results. This proves the theory that the likelihood of sustainability increases if staff are involved in the change. A Market and Opinion Research International (MORI) research study demonstrated that staff who feel that they are kept well informed are twice as likely to:

- feel involved with the organisation
- understand the overall objectives
- recognise the goals
- feel secure in their role
- feel that they can make the best use of their skills and abilities.

A feeling of involvement amongst staff and the opportunity to influence the change can in itself increase efficiency and job satisfaction. In addition to this, getting staff involved in the process will itself impact on their work and workload. Within their working day they will be needed to participate in new or extended meetings or discussions, think about things in a different way and possibly undertake tasks that they had not previously had to do. Therefore, unless they can be fully released from their normal duties there is usually some increased workload for staff which could lead to concern, dissatisfaction and disengagement. Part of this burden was lessened by ensuring extra/supplementary staff was available for the RPC projects duration. Whilst extra workload such as elements of data collection was still required this was perceived as good clinical practice rather than an element for just the program evaluation.

It is certainly worth reviewing any issues at regular intervals with the staff group that are working with or are affected by the change. This effectively provides another forum where staff can voice where things are going well or not in terms of both their role and general efficiency of the new process. Within the RPC projects this was achieved by utilising clinical working groups and also within the multidisciplinary meetings. It is important to maintain a forum so that there is continuous assessment that can lead to continuous improvement. Whether reviewing before or after full implementation it is useful to maintain a balanced view and the 'Six thinking hats tool' (de Bono, 1999) may be helpful during these discussions. Some useful review points include:

- look for areas that are working well and try to learn from them
- identify areas where there appear to be difficulties and see where these can be better supported.

For example, if the review is during the improvement initiative: try a more incremental implementation approach: break the change into smaller segments and implement some aspects later: identify additional staff that could help; identify information needs and support these. If the review is after the improvement has been implemented, break down the elements of any inefficiency and identify small cycles of change to bring new improvements

- re-set the clock: if you are expecting too much, too quickly, think about expanding the time frame. Do you need to go back and improve some of the process even more. If so apply a new timeframe to this
- re-organise or re-establish some timescales and milestones: identify interim objectives while keeping your sights firmly planted on producing or maintaining the full process change.

Remember full implementation of a new process can be traumatic and complex. Full attention and support should be available for unanticipated or unintended consequences that may occur. These might not happen or manifest themselves immediately so continue to monitor, review and provide an effective forum for staff. Take a positive view of any problems and treat them as a step towards a continuous improvement cycle. It is important to highlight that a new model of care such as RPC represents a substantial change in work practices, not only within organisations but across organisations.

It is therefore critical that when a difficulty (of any kind but in particular difficulties that add complexity to staff work) is experienced, it is important to try to correct it as soon as possible.

Countless change programs have faltered despite well-argued logic, rational and technical argument because people in positions of power and authority wavered in their support.

The research in developing and implementing organisational changes emphasises the importance of support from senior leaders. Similarly the theme of leadership importance has also been specifically identified in terms of sustaining change. Ham (2003) identified 'organisational leadership' as a significant factor of whether efforts would sustain improvements or not. When interviewed, improvement project leads said that in their experience a main factor in ensuring sustainability was 'clear and credible leadership, providing support and ensuring continuing priority of service improvement' (Research into Practice Team, 2003b). While further independent research also cites the presence of strong local leadership which includes the chief executive, other senior managers and clinicians as being essential for 'mainstreaming' modernisation efforts (Matrix, 2003). Senge (1999) also comments on the importance of leadership in sustaining change with the focus on continual improvement so that we build organisations that are able to continually adapt and reinvent. There is a strong recognition that leadership is not necessarily hierarchical and leaders can come from different levels within organisations.

This also supports the view that change in modern organisations cannot be led by one individual. That many people are required to help with the leadership task within their sphere of influence and activity. Many commentators reinforce this notion by describing the importance of having leaders at every level within the organisation (Kotter, 1995, Shortell, 2002, Senge, 1999). There are extremely complex issues in Palliative Care service delivery that no single agency can be responsible for. Delivering effective and seamless services for clients – particularly those with complex needs – across a range of care settings requires agencies to work together, respecting each others priorities, and understanding each others roles and responsibilities. NSW Health (2006) suggests we need to collaborate when;

- When clients or communities have complex needs that cannot be met by a single policy, program or service
- When other agencies (e.g. State, Commonwealth, Local Government, non-government or private sector agencies) affect your services or clients; or your policies, programs or services have a "flow-on" effect to others.

This is certainly the case for palliative care service provision in rural Australia. Collaboration is a requirement to improved outcomes. The challenge is to secure the place of palliative care as an integral part of health care across Australia, routinely available within local communities to those people who need it. Care and support for people who are dying and their families needs are to be built not only into health care services, but into the fabric of communities and their support networks. Care built around the principles of palliative care needs to be available to anyone who is dying, whatever the cause of death. Working in conjunction with partner organisations will support in;

- developing or implementing a shared strategy / service model that involves other agencies to better meet the needs of
- To develop or implement more effective solutions to solve issues or problems that involve other government or non-government agencies
- To develop more innovative or effective or efficient ways to provide palliative care services and use all of the available resources

An important factor in ensuring sustainable change is the engagement of clinicians in the redesign and improvement of services. While evidence suggests that many clinicians are committed to improving services in principle, present levels of engagement within the clinical field could still be improved. Clinician scepticism and the relative scarcity of clinicians willing to take on the challenges and responsibility of clinical leadership for improvement are significant risks to sustaining improvement.

Redesigned systems of healthcare delivery almost always require clinicians to change the way they work both at an individual level and collectively within their professional groups. It is therefore vital

to engage clinicians in the redesign process ensuring that new ways of working take account of clinicians' priorities and needs (Kilo 1999). Because any profession is most likely to listen to advocates who understand their values and challenges, a clinical leader or champion is very important in gaining the support of other clinicians. Clinical champions have been identified at all RPC sites. A unique feature within the Adelaide Hills project not seen in the original GAPS model is the role of GP Advisor. This evolved in response to the historically low number of referrals by GPs to the Adelaide Hills Palliative Care Service. In pre-project discussions it was identified that GPs were not referring particularly well to the palliative care service, with referral figures from 2002/2003 demonstrating that only 12% of total referrals were from GPs, whilst 23% of referrals were patients and relatives who self-referred.

The role of the GP advisor is to:

- Act as a palliative care liaison and resource within the Division of General Practice, providing clinical support during working hours to local GPs
- Act as an advocate for the ongoing development of palliative care in
- General practice
- Establish a case conference strategy for Palliative Care within a multidisciplinary forum.

The GP Advisor works within the multidisciplinary forum to provide direct clinical support to GPs via case conferences, following up on issues as required. Other initiatives have included provision of clinical updates and narratives on varying palliative care issues; and chairing continuing professional development (CPD) events. Small group learning for GP's, a Royal Australian College of General Practitioners initiative, facilitated by the GP Advisor is also used as a means of developing regional GP champions.

New processes are more likely to be sustained if there is evidence to support their advantages over the existing or old processes. Staff need to be able to understand and believe that the new process has benefits, they are not just for the sake of a short term project that will soon potentially lose its funding source. Staff are more likely to support the change if at least some of these benefits are immediately obvious. The material that follows offers suggestions on what you can be done if the benefits are not immediately obvious or if there is limited evidence supporting the advantages and value of the change. It is important to be able to identify the beneficial impact of the intended change otherwise there is little or no incentive for participation and involvement. The harder it is for people to see the benefits for the patients, themselves and the organisation, the harder it will be to convince them to accept the proposed or new change.

The NHS Institute for Innovation and Improvement suggest two key elements, which will support in identifying and demonstrating the evidence and benefits for this change. The first is identifying the benefits and the second is being able to effectively communicate the evidence. The more difficult it is to appreciate the benefits of a new or revised process, even if there is evidence to support it, the less likely staff will be to engage in the process of change. The more the benefits are immediately obvious the more likely that staff will support the new change.

Gathering evidence of the continued effect of the project can be very important to sustainability. It provides the front line staff and other governance committee with information upon which they can act to continue to support or spread a change. Three key questions that might be considered at this point are:

- who needs to see the evidence?
- what one or two measures will they be interested in seeing?
- how can it be best presented?

A guiding principle is to identify the most important customers of your data. It may be the staff opinion leaders who will influence others to either support or oppose the improvement. It could be the senior leadership team who will remove any barriers there may be to sustainability. It could be the administrative staff who are most affected by the change. It could be the patients themselves. Or hopefully it will be a combination of all of the above.

Being able to both demonstrate the potential or actual benefits of an improvement is critical in terms of both starting your project and holding onto the gains once the change has been implemented. There are two key elements to this section; identifying the evidence and communication the benefits. A number of tried and tested tools and techniques are available including small scale testing using Plan, Do, Study, Act (PDSA) cycles, patient shadowing, process mapping and patient stories. These are complimentary and can be used together as well as singularly. It is important to remember to focus communication methods for those who you want to receive the information.

Adaptability can be very important in determining whether a new or improved process will be sustained over the long run. There are three situations where this adaptability can be very important:

1. During the design stage when you want to use an idea from outside the organisation but must adapt it to fit within your organisation, as with the Rural Palliative Care Program
2. During a period when your organisation changes (e.g. changes in people, location, structure) and the relevance of the new or improved process is being questioned and
3. Over time as the new process itself becomes a candidate for further improvement.

It is important to recognise that not all changes which are successful in other organisations and areas, will be either fully replicable or successful within your own and this has been the case within the RPC. Project elements have required careful adaptation that takes into account the unique characteristics of the adopting organisation.

Rogers (1995) identifies five categories which increase the likelihood of a sustainable change. The new system will:

- have a relative advantage compared to the current system
- be compatible with existing practices of the adopting organisation
- be easy to understand
- be observable in demonstration sites
- be able to be tested and revised to fit local needs.

(Rogers, 1995) Locock (2001) stresses the important influence of the local context. Unless those involved in the local change process can see that the change will improve on their current process, and is something that they can adapt to fit their own unique organisation and local practices, they are unlikely to be persuaded. It is in this context that the Rural Palliative Care program specifically aims to support the development of more collaborative models of palliative care, for people living in rural and remote areas, drawing on key aspects taken from the GAPS model and examining how these are transferred and applied using varied approaches across a range of settings. It has never been a 'one size fits all' approach rather the view is, how would this strategy be adopted in a different setting. Whether the organisation is looking for a new change idea from others or planning for the future success of continuous improvement it is important to consider adaptability as a key factor for sustainability. There are many improved services that can be drawn upon for ideas and inspiration but they must be considered and adapted to fit with a different organisation.

Unanticipated organisational change can disrupt the improvement initiative however they can and do bring opportunities.

When the improvement has completed its pilot testing and begins full-scale implementation a baseline will have been established that will allow you to determine whether the desired level of improvement has occurred. The message within this section is that both measurement and communication must continue if you are to sustain or 'hold the gains'. If staff are not able to identify and document either ongoing improvement or slippage they will be unable to either take corrective

action or think about how the process could be improved even more. There is a resonance in the saying 'we manage what we measure'. More than just maintaining position, measurement and communication help the team to look toward ongoing improvement of their processes beyond when the change is implemented. This involves routinely collecting and presenting information that demonstrates the continuing impact of the change. In order to increase the likelihood of sustainability measures should be routinely collected in order to illustrate what is happening (e.g. Are we continuing to achieve the reduction in waiting time?). Reviewing the measures that were used during the design and testing phases of the project is a good place to start when deciding what to measure to support the improvement beyond the formal end of the project or initiative.

However, you should aim to collect data that will give you the best picture and keep things simple and minimal. Think about which measures were most useful during the implementation phase, which was the best measure in terms of identifying overall improvement, which measure did the team relate to most and which measure would give the Senior Leadership team the best information overall.

The following principles from the Improvement Leaders Guide to Measurement (2003) provide a useful framework:

- seek usefulness, not perfection, in measurement
- be sure you use a small set of measures that reflect goals and aims
- keep measurement simple
- write down operational definitions of measures
- consider measuring small, representative samples
- build measurement into daily work

A concern often raised is "We already have too many things to measure".

This is an important consideration when deciding on which measure(s) to choose for ongoing reporting. Here are some things to consider when selecting the measure(s) to employ:

- does it accurately and reliably measure performance of the changed process?
- can the measure(s) be easily incorporated into the mainstream fabric of reporting?
- can the needed data be easily collected by the team?
- can existing measures be used to monitor sustainability?
- are we currently measuring something that is not used or useful?
- is there anything we can stop measuring?

Often data is collected and not correctly utilised, reports are not generated or not understood. The data needs to be communicated in a way that will motivate efforts to sustain the change and promote action to improve if a problem is found. To do so regular communication must be targeted to staff of the whole system within which the changed process sits and also available to others within the wider system. For example, other clinicians, senior leaders and patients, This will also act as a means of motivating continued support for the change and cooperation as further improvements are made. Visual display of measures/data is a very powerful way to communicate the improvements and graphs and diagrams provide a good mechanism for demonstrating trends, data and flows. They can tell a powerful story and provide a means of continually building your improvement evidence. It is important however to make graphs and diagrams clear and very easy to understand so that everyone who sees it is able to quickly appreciate the message.

A very effective way of maintaining involvement is by establishing a real time measurement system. If there are systems and skills in place to monitor and continually evaluate the impact of the change it is more likely to be sustained. (Greenhalgh et al, 2004). As Schneider (2001) highlights, practitioners are always searching for any tool that saves time and decreases the amount of information to remember. Technology and its use in the healthcare field is steadily growing (Wilkinson 2001). The GAPS project chose to trial as its information system 'PaICIS', a clinical information system designed by Unique Database Solutions for use exclusively with palliative care. It's forerunner, the 'West Australia Rural Palliative Care Database' (WARP CD) is in current use at eight sites in West Australia. The WARP CD was the result of ongoing development of the Albany Palliative Care Team Database, used since 1995 to assist the development of

coordinated team approach to palliative care in that Western Australian community. The database records the following:

Demographic details

- Diagnoses, metastases and complications
- Inpatient, Ambulatory and Domiciliary Service provision
- Symptomatology (WA Symptom Assessment Scale)
- Functional Status
- Professional and Family Carer Details
- Consultations and Care Plans.

PaICIS features an advanced, user-friendly interface via mouse and/or keyboard. An emphasis on visually enhanced feedback of the entered data is maintained throughout the application to facilitate its use for decision support purposes. PaICIS is ideally suited to use by multidisciplinary services operating from multiple sites. The data exportation, importation and merging tools allow data for single or multiple patients to be shared between sites and services using securely encrypted files. PaICIS incorporates a flexible tool for creating links to existing patient information systems to enable the importation of patient demographic details.

Many methods were utilised to ensure this data was being communicated effectively; the list below will give you some ideas:

- Multidisciplinary meetings (eg.clinical data)
- Governance meetings (eg.service utilisation)
- Newsletters
- Local press, radio etc
- Presentation at conferences
- Formal reports for the evaluation Team and funding bodies.

Kotter (1995) reports that under-communicating is ten times more likely to occur in transformation efforts that fail. Alongside stressing the importance of using every available communication channel he also describes as critical that staff and leaders 'walk the talk' by demonstrating the importance of the change in both words and deeds.

Taking into account the information already discussed within this paper highlights the need for utilisation of available diagnostic tools as useful predictors of sustainability, identifying weaknesses and opportunities for improvement.

In 2000 NSW health published health indicators to help with building capacity in health promotion (January 2000) this 60 page documents has multiple tools that are useful in an assessment of services. The document can be accessed via NSW health at <http://www.health.nsw.gov.au/pubs/i/pdf/capbuild.pdf> .within this document includes a sustainability checklist including factors that are known to predict uptake and continuation of programs. The checklist includes items about program design and implementation factors, and identifies the five following areas;

- People with a stake in the program- funders administrators, consumers/ beneficiaries, other agencies- have been aware of the program and/or involved in its development
- The program has shown itself to be effective, effects are visible and acknowledged
- The organisation which you intend to host the program in the future has been making some real or in kind support to the program in the past
- Prospects for the program to acquire or generate some additional funds or resources for the future are good
- The program has involved formal and/or informal training of people whose skills and interest are retained in the program or its immediate environment

The document identifies six further factors within the organisational setting which are known to relate to the survival of a program, they are;

- The organisation that you intend to host the program in the future is mature (developed, stable, resourceful). It is likely to provide a strong organisational base for the program
- The mission of the program is compatible with the mission and activities of the host organisation
- Part of the programs essential business is integrated into other aspects of the host organisation i.e. In policies, practices, responsibilities etc. that is, the program does not exist as an entirely separate entity
- There is someone with authority or seniority, other than the director of the program itself, who is an advocate for the program at high levels within the organisation
- The program is well supported in the organisation. that is it is not under threat and there are few rivals in the organisation that could benefit from the closure of the program
- The intended host organisation has a history of innovation or developing new responses to situations in its environment

The final set of factors is about the broader community environment which effect how long programs last, they are;

- There is a favorable external environment for the program that is, the values and mission fit well with community opinion, and the policy environment
- People in the community, or other agencies and organisations, will advocate for and maintain a demand for the existence of the program should it be threatened
- Organisations that are similar to the intended host organisation have taken the step of supporting programs somewhat like your program

Scoring the factors is a simple process of choosing between four Responses;

- Yes, fully
- Yes, in part
- No
- Don't know

The process is straightforward and time efficient yet provides relevant data that can acted upon and used as a benchmark for future assessments.

Within the Rural Palliative Care Program the evaluators (Centre for Health Service development, university of Wollongong) adapted this tool to include goals, objectives and strategies for sustainability. This ensures these areas are explored in-depth and increase the opportunity for appropriate intervention. Within the Rural Palliative Care program this documented was completed at base line, mid point and at the end of the projects funding cycle.

In May 2006 the evaluators reported that, upon review the largest differences between the four categories of responses of this tool are evident in the 'yes, in part' columns. During baseline assessments, 24% of respondents selected 'yes, in part', compared to 63% from the mid-point assessments. There is also a reduction in the number of 'don't know' responses which were initially 31% at baseline and decreased to 8% at mid-point. When the 'yes, fully' and 'yes, in part' responses are combined, we get a total of 67% for the baseline and 87% for the mid-point responses. This indicates a 21% increase in positive responses. This is important information for project workers, managers and funders. In summary the use of such a tool can provide;

- A process for routinely measuring performance,
- A mechanism in place to detect the source of any performance problem that is found,
- A vehicle for communicating the results of the performance monitoring and analysis,

The use of a relevant tool or suite of tools is recommended and an excellent example can be accessed via the Centre for Health Service Developments website.

http://chsd.uow.edu.au/Publications/2004_pubs/The%20Palliative%20Care%20Evaluation%20Tool%20Kit.pdf

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