SCALING UP INNOVATIONS ACROSS HEALTH CARE SYSTEMS

Views of stakeholders

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1. INTRODUCTION AND OBJECTIVES

1.1 Introduction

Ensuring safety and quality, optimal patient experiences and outcomes is a priority for all health systems. However, within a context of finite resources, there are growing concerns that the rate of growth in health expenditure is not sustainable and as such patient safety and quality may be compromised. Exacerbated by rapid population ageing and changing care system requirements, governments and society are faced with significant challenges and difficult choices.

The NSW Agency for Clinical Innovation (ACI), is charged with designing and implementing state-wide, evidence-informed improvements to the way care is provided to people accessing the NSW health system. To optimise the impact of the ACI, it is essential that the initiatives of the ACI make best use of evidence for methods for ‘scaling up’ small-scale, locally effective projects to achieve system wide improvements. Given the complexity of the health system, which involves a tortuous interplay of social factors, financing systems, organisational structures and processes, health technologies, and personal behaviours, it is expected at the outset that the evidence base for achieving, and importantly sustaining, change at a systems level will not take the form of hard and fast statements about ‘what works’. Rather, the evidence will take the form of broad statements about ‘what tends to work, for whom, in what circumstances’ and broad principles of ‘action and contingent approaches’ (Best et al., 2012).

ACI engaged Inca Consulting Pty Ltd to undertake in-depth interviews with a range of people (across NSW and other jurisdictions) involved in the process of supporting the implementation of innovation in health systems. The research is part of a wider program of research to inform the work of ACI. The overarching aim of these pieces of work is to better understand the complex interplay of factors that increase the success of transformational change across a large and complex health system, including comment on the issues that make an initiative particularly vulnerable to failure if not addressed. Combined, the purpose of this program of research is to provide ACI and its Clinical Networks, Institutes and Taskforces with a relevant set of evidence-informed strategies to best enable and evaluate transformational and sustainable large system change across the NSW Health System.
1.2 Research objectives

The study set out to validate and compare what is known in the literature with what is practiced in the health sector. The objective of the study was to better understand the complex interplay of factors that influence the translation and scaling up of innovations and research discoveries to transformational change across a large and complex health system.

More specifically, the study set out to answer the following questions:

1. What are the key mechanisms or processes that influence and drive innovation and change in a health system, including sustainability of change?
2. What factors make a new initiative particularly vulnerable to failure if not addressed?
3. What mechanisms are ACI currently using to influence the adoption of innovation and what effect do they have on health system performance?
4. Do mechanisms vary in effectiveness across issue and context?
5. What is the role of ACI in the efforts to advance new ideas and see new initiatives implemented, and what mechanisms should ACI adopt to maximise and monitor outcomes for the NSW Health System?
2. APPROACH TO THE RESEARCH

The research was modest in scale and entirely qualitative in nature. Inca Consulting was provided with a selection of papers to review in order to become more familiar with the subject matter and was provided with further briefing by the ACI research manager. An interview guide was designed by ACI and Inca Consulting to meet the objectives of the research and to build on the themes to emerge from the review of literature undertaken as part of the wider project. The interview guide is included as an appendix to this report.

ACI selected 21 individuals representing ACI, a number of Local Health Districts (LHDs), the Clinical Excellence Commission, NSW Cancer Institute, NSW Ministry of Health and the innovation/redesign/improvement units within the health departments of Queensland, Victoria and New Zealand. An approach email was sent by ACI to all of the identified people requesting their participation.

Of the 20 individuals contacted, 17 were interviewed. Interviews were approximately one hour in duration. Most (11) were conducted face to face and five were conducted by telephone. All interviews were conducted by one researcher from Inca Consulting. Most of the interviews were audio taped with the consent of respondents.

The findings set out in this report are generated from the common themes and issues raised through the interviews, noting that despite the use of a discussion guide, each interview unfolded in a unique way. The findings are limited to the issues raised by respondents but it should be acknowledged that an analytical overlay is required in assembling a coherent set of findings from the interviews.
3. FINDINGS

3.1 Overview of findings

The discussions with informants related to the basic scenario of taking some innovation that has been shown to improve health outcomes and efficiency of health care delivery, and ‘up-scaling’ it to an initiative to be implemented at a state-wide level. The research did not touch on the questions of how innovation occurs and what allows it to occur, but rather what enables and inhibits its wider application.

The discussions also tended to be confined to scenarios where innovative systems or processes (and the change required to implement them) were promoted to LHDs and others rather than mandated. A clear distinction was drawn here between funded programs (where LHDs were resourced to make some change required as part of a policy shift) and un-funded initiatives that were being advanced because of the benefits they bring for patients and/or for a LHDs finances. This is of course congruent with the fact that ACI was established to promote health system innovations and to support their implementation, without the ability to place obligation on LHDs or other organisations.

The discussions also only lasted for a maximum of one hour each. There was not the opportunity for any one respondent to convey everything they might have known about innovation and change in the health system.

In the context of these constraints, informants identified a number of broad factors that underpinned the successful and sustainable ‘up-scaling’ of innovative initiatives:

- a sound business case or ‘case for change’
- good preparation for the change process and thought given to how the initiative could be adapted to different contexts
- good engagement of clinicians, administrators and others
- good support provided through the implementation phase
- the right structures and strategies in place to coordinate the implementation of innovation across the system.

These broad topics are discussed in significant detail in the following sections.
3.2 Developing the case for change

Interviewees all agreed that successful innovation projects and processes were almost always underpinned by a strong ‘business case’ or a ‘case for change’. Where there was the intention to take some innovation trialled in a small setting and to apply it on a wider scale, a sound business case was seen as essential in garnering the support of decision makers and influential stakeholders.

Interviewees identified a number of attributes of a compelling case for change. Firstly, it was noted that there needed to be a clear definition of a problem or need, with the extent of that problem or need quantified in the strongest possible terms. It was stressed that the impacts of a given problem needed to be (to the extent possible) expressed in terms of clinical outcomes, patient experience, costs to the health care system and workforce impacts. Some thought it was especially useful to make comparisons with other jurisdictions in order to emphasise the extent of a given problem.

A good business case was also thought to require relevant contextual information. For example, data on demographic trends, increasing costs of health care, workforce trends, epidemiological trends and so forth could help to illustrate root causes, exacerbating factors and the potential worsening of a problem or need. Several people saw that a good business case should include an analysis of the cost of doing nothing, again expressed in terms of clinical outcomes, patient experience, cost to government etc, extrapolated over a sensible time period. As one person said “You need to ask ‘what are the consequences of not changing?’”

Of course, any business case needs to propose a solution or means of addressing a problem or need. It was noted though that it was useful for a business case to include a range of potential responses, the strengths and weaknesses of each and justification for a preferred option. It was sometimes said that business cases were often developed to justify a pre-determined project, or someone’s ‘hobby horse’ without there being a thorough exploration of possible responses. As one person said: “[some people] want to jump straight to the solution.” It was widely thought that business cases were more persuasive when there was some discussion of a range of options and their implications.

Perhaps most importantly, a good presentation of the evidence to demonstrate the effectiveness of a proposed new process or system was seen as crucial. In particular, interviewees noted that clinicians, administrators and other decision makers all wanted to see the strongest possible evidence of the short and long-term improvements that
have been made by introducing change elsewhere. This evidence could be derived from small-scale trials of a new approach, a system-wide approach used in another jurisdiction or from modelling health and financial impacts. Preferably, a business case would provide evidence of improved outcomes across a number of jurisdictions or health service contexts (though it was acknowledged this is usually not possible). The basic point that was being made, however, was that decision makers needed to see robust data to be satisfied that a system change would deliver the intended benefits, regardless of the local context.

In addition to data relating to past experience, interviewees also said that business cases needed to provide sound projections of the benefits of introducing the change across the State or within an LHD. Again, these projections would ideally quantify the anticipated benefits for patients, health professionals and government. It was commonly noted that as far as possible, these projections needed to relate to the key performance indicators (KPIs) that have been set for LHDs and individual decision makers. It was also noted that it was helpful to make the link between projected benefits and overarching strategic goals pertaining to safety, quality, patient experience and so on.

Providing case studies and other information regarding the experience of implementing change in other jurisdictions, including any ancillary benefits, was also seen as persuasive. Some interviewees said that they had had success with using vignettes to demonstrate the everyday benefits that a new system or process had provided, the changes that had to be made, the barriers that had to be overcome and the reflections of staff on the ease with which the changes could be brought about.

Another important inclusion in a business case is an analysis of the resource implications of implementing the change. It was noted that decisions were almost always made in light of what new human resources might be required, how resources needed to be reallocated, where people needed to be physically located, what capital investment was required and so forth. It was also suggested that the return on investment for any cost outlays needed to be calculated and clearly presented. To use the words of one interviewee: “You need to clearly state the case for change. There needs to be good costings.” As an aside, it was noted by one interviewee that new initiatives (such as a new model of care) tended to rely on the addition of new human resources, often a network of care coordinators, to deliver the intended benefits. It was noted that this often raised a red (or at least orange) flag for health administrators, regardless of the return on investment equation. The question was raised as to whether there was always full consideration of systems or processes that might deliver the intended benefits without the need for additional staff.
A number of interviewees noted that, often, change was most easily brought about where the problem was clear to see, where the solutions were obvious and easy to implement and where patients, clinicians and government all benefited. As one person said “sometimes it's just a no-brainer - where it makes complete clinical and financial sense and where it's easy to implement.” It was consistently noted that a strong business case – and one that would help to carry a given idea forward - was one that was compelling not just to a particular individual or group of individuals, but compelling to all relevant stakeholders. To provide the simplest example here, interviewees commonly made the point that clinicians tended to focus on health outcomes while administrators tended to focus on financial outcomes. This is not to say that clinicians are disinterested in efficiency and managers disinterested in health outcomes but that their roles and professional backgrounds require them to focus more heavily on certain things. The point that was being made was that anyone preparing a business case for some new initiative should consider how to frame the argument for different target audiences.

A number of people suggested that the development of a business case needed to be a multi-disciplinary and collaborative effort and that the ‘more eyes’ that were run over it the better.

Lastly, it was noted that a compelling business case needed to be professionally ‘packaged’ in a way that conveyed the hard work and thought that had gone into preparing it. Without suggesting that decision makers are more impressed by style than substance, it was noted that ‘sloppy’ presentation could easily result in the business case being overlooked, despite its merits. A further point was made that a good business case did not just provide supporting data but interpretation of that data. It was noted that statistics could easily (and even deliberately) be misinterpreted and that convincing analysis and interpretation was all-important. As one informant said: “Converting data into excellent information is the key.”

3.3 Preparing for the change and ‘flexible standardisation’

However compelling the argument for the introduction of some new system or process, there are still barriers to be overcome in ‘taking the product to market’. Informants noted that there was no shortage of good ideas and sound cases for change that had not been taken any further, for one reason or another. Informants also reflected on what underpinned change initiatives that had been widely adopted and judged to be successful.
A particular barrier that was identified was the tendency of people to take the view that ‘yes, it worked over there but it won’t work here’. The point was consistently made that change initiatives – if they are to be adopted - usually needed to be tailored to a particular context, whether that be the nature of the geographic area, the size of and distances between health facilities, organisational structure, local politics or whatever. As one informant said: “in health, one size never fits all.” A tension was identified here in terms of the difficulty of tailoring an initiative to a local context while preserving the fidelity of the proven approach. It was noted that the outcomes achieved in one context could be different in another context, whether because of those contextual factors or because the approach had been altered to fit with that context. It was stressed that this understanding needed to be in the background of any effort to translate initiatives from one place to another.

There were, however, some different points of view expressed here. Some informants were of the view that, in reality, there always needed to be a process of adapting an initiative to local circumstances and that decision makers could easily reject an idea if there was not the flexibility to do so. It was also commonly noted that an initiative may simply be unworkable if applied in a rigid format. As one person said: “You need to have a good appreciation for the geographical context…how do we translate evidence to the local context?”

Other informants thought that at times there were too many concessions made to allow initiatives to be implemented and that service standardisation suffered as a result. As one person said: “We pay too much heed to context and different locations. There needs to be an umpire to say which approach is best and that’s it.” And as another informant said: “Everyone thinks they’re unique and special.”

On balance, the view was that successful large-scale change processes struck the right balance between the fidelity of the proven ‘model’ and the way it is adapted to local context. It was noted that each initiative is different and the degree to which the model can be ‘tinkered with’ depends on the nature of each initiative. Informants thought that there was no ‘rule’ that should be applied here other than to identify the core, ‘non-negotiable’ elements of the initiative and the areas where some modification is possible – a process of ‘flexible standardisation’. As one person said: “You need to work out what things must be done, what things should be done and what things would be nice to do.” It was also noted that there needed to be some acceptance of the fact that outcomes may not be as strong where an initiative is moulded to local circumstances but that some good outcomes are better than none.
With this in mind, it was thought to be important that anyone trying to drive the adoption of some new initiative in, say, a Local Health district, remains open to new ideas. It was suggested that a new initiative needed to be presented in the form of: ‘here’s something we know works well, how do you see that we can make it work here?’ What was described was a collaborative process of refining and adapting the initiative to the point where all parties are satisfied that the project should proceed. As a couple of people said:

“Let the LHD administrators decide who sits where. You can help them wrestle with it and make some suggestions but you can’t be too prescriptive.”

“You need to appreciate that all contexts are different and that local staff will need to make it work.”

“You have to have a willingness to have frank discussions…allowing people to speak their minds.”

It was also noted that regardless of whether a new model of care or other initiative needed to be altered to fit with a given context, there was a need for local actors to be able to take some ownership and to feel that the approach had been tailored to their environment. As one person said: “Sometimes it just comes down to putting their logo on the flowchart.”

In short, the message from informants was that, in bringing about positive change, there should be a focus on the outcomes and an appreciation that there is more than one way to achieve them. As one person said “Don’t get siloed in your own thoughts.”

One informant made the point that efforts to foist ideas or new systems on people and organisations were often fraught from the outset. It was suggested that, instead, the approach should be to advertise the initiative (and the underlying need for it) and to support those who want to pursue it. This was likened to an Expression of Interest (EOI) process – “here’s a problem, here’s a way to fix it, who wants to take part?” Another respondent added: “The aim is to get them to grab it out of our hands – we need products that they want.” It was suggested that this approach allowed for resources to be directed towards supporting willing participants rather than battling against unwilling ones.

Other informants spoke of the almost serendipitous way in which some initiatives ‘fly’ and others do not. It was noted that all kinds of factors could have an impact on whether there is interest in pursuing a particular change project – a recent adverse event, new management, a statement from the Minister, media attention on a particular issue, someone having attended a relevant conference etc. Conversely, initiatives may
not be pursued during times of instability or tumult or when there is a focus on other matters. In short, decisions are not always made in a purely rational way.

One informant said: “You have to take your opportunities” meaning that the process of bringing about change is one of planting seeds and then waiting for the circumstances to be suitable to take the initiative forward. It was said that those trying to drive change needed to “make hay while the sun shines” but to also be constantly on the look out for opportunities to coat-tail on other initiatives or to quickly position the initiative as a response to some emergent problem or ‘hot topic’. It was also noted that there were times, in particular due to the electoral cycle, where it was difficult to bring about change. The point was made that this is a simple reality and should not cause frustration. It was also noted that this time should not be squandered but rather used to prepare for the inevitable time of greater stability.

3.4 Promoting change through stakeholder engagement

A very common theme in the research (and indeed the literature on systems change) was the importance of understanding that implementing any new initiative requires individuals to change, and sometimes, for organisational culture to change. It was noted that making system changes was relatively easy when compared with the process of changing people's attitudes and behaviour. As a couple of people noted:

“There can be an inertia at an individual level. Reducing that inertia is often the challenge.”

“There’s a human resistance to change.”

All interviewees acknowledged the need for an effective engagement strategy to accompany any change process. Indeed, some initiatives depend totally on changing the behaviour of people and the successful engagement and involvement of individuals. It was noted that many good initiatives had fallen by the wayside because the engagement of clinicians, administrators and others was handled poorly. For example:

“Typically, we rush to implement too quickly.”

“You need to invest lots of time up front on engagement. It may take longer to implement but the desired impact is reached more quickly.”

“To get large scale change, you need to consider all and engage with all stakeholders – ask what do they need from us and what do we need from them?”
Informants spoke of clinicians and managers/administrators as the two groups that typically need to be engaged and it was highlighted through the research that power and influence resides with both these groups. In very simple terms, the challenge was usually in encouraging clinicians to change their behaviour or approach and encouraging administrators to allocate funds to allow the change to occur. As one person noted, change happened “when there’s a marriage between clinical and administrative thinking.”

However, the concept of ‘engagement’ is not a straightforward one. It can mean different things to different people, it can occur through a variety of means and it can manifest itself in different ways. For example, someone can be said to be engaged with a process simply because they know about it. Another person may have engaged with a process to the degree that they are leading it. It was stressed that there always needed to be thought given to how and to what degree people are engaged, not just who is engaged. As one informant said: “It’s not about engagement, we want involvement.”

It was noted that engagement should start at the very beginning when an innovation is being formulated and continue throughout the implementation phase. The engagement process was described by one person as “building the momentum for change”, meaning that by engaging people individually, collective action and systems change can result.

It was common for informants to stress the importance of having clinicians to champion the change process/innovation project. It was repeatedly noted that clinicians are more responsive to, and influenced by, their peers rather than by administrators or policy makers. It was also noted that administrators were generally responsive to a critical mass of clinicians lobbying for some change and in fact were at times reluctant to take an interest unless there was strong support from clinicians. In general, innovations that had been developed by clinicians, that had surfaced through a clinical network and that were championed by clinicians were thought to be far more likely to be embraced than ‘top down’ initiatives. It was also consistently stressed that the success of an initiative depended on the credibility (and temperament) of the clinician(s) championing the cause. Following are a few relevant quotations from respondents:

“Clinicians are usually very responsive to [clinical network] working group findings.”

“Picking the right change agent is important…a person with trust and credibility.”
“You don’t want a champion who’s a loose cannon. You have to be careful.”

Informants made mention of the tendency of all individuals and organisations to be focused more heavily on their own affairs and local circumstances than to focus on the ‘big picture’. Like anywhere, the people and organisations that make up the health sector can sometimes ‘wear blinkers’. The challenge of getting people to think from a systems perspective rather than just thinking about their ‘own patch’ was said to be significant. Equally, it was suggested that people looking to introduce change needed to think carefully about the implications for others. It was noted that there are usually many vested interests in any change process and that these needed to be considered when shaping a plan to introduce change. As one person said: “You need to know whose going to be making the money?”

Given this, it was repeatedly noted that the benefits associated with a new initiative and the requirements of individuals and organisations needed to be personalised – that is, expressed in terms of ‘what does this mean for you?’ To put this another way, the engagement process was said to be one of ‘finding the right buttons to push’ to get people to take an interest, to contemplate making some change and to work with others to see the change brought about:

“It’s about helping them to understand what’s in it for them.”

“It’s about asking yourself ‘How do I get this project higher on your agenda?’”

“There’s a tendency to push pure statistical data which is not convincing to everyone. You need to twig the heartstrings.”

“You need to make sure there’s something in it for everyone.”

For clinicians, the first ‘button’ to push was thought to be improved clinical outcomes for patients. However, it was also noted that clinicians could be more likely to engage if the innovation could be shown to have a positive impact on their income, work/life balance, sessional arrangements, degree of autonomy, exposure to other types of health professionals, the opportunity to publish etc. Conversely, if the new initiative posed threats in these areas or had negative impacts on clinicians, resistance should be expected.

For health administrators, the first ‘button’ to push was thought to be reduced costs or more efficient use of resources. However it was often noted that initiatives would be more warmly received if the benefits were closely aligned with the KPIs set for LHDs. In fact, several interviewees said that initiatives that could be shown to
(inexpensively) lead to improvements in KPIs relating to patient safety, quality and patient experience were much more likely to gain the support of management. It was suggested that as far as possible, the business case and efforts to engage management should try to make these links. Following are some illustrative quotes:

“*You need to talk to the KPIs – financial sustainability, infection control, surgery waiting time, ED waiting times.*”

“*You need to push their buttons, address their major issues, their KPIs.*”

It was also noted that some administrators at least were motivated by a desire to keep ahead of, or keep up with, other LHDs. Some reported that they had had success in using ‘league tables’ as a way of prompting action.

Of course, there is always **resistance to change.** Part of the challenge, for those trying to ‘sell’ the need for change and to then make it happen, is in managing contrary views, dissent and inertia. The point was made that resistance should always be expected and never be seen as a reason to ‘give up’. It was noted that the engagement process was, more often than not, about understanding the nature of the inevitable resistance and finding ways to overcome it or side-step it:

“*You have to surface the resistance and then address it. If you’re not experiencing resistance, you just haven’t found it. It’s healthy if we get yelled at a lot.*”

“*Look for where the barriers are, find the people who will resist – go see them and try to understand them.*”

One informant said that it was useful to think about health system change processes using behaviour change models applied to various social issues, smoking cessation for example. The point was that people should not be regarded as ‘opponents’ but rather as being at different points on a continuum relating to the preparedness to change – pre-contemplation, contemplation, preparation etc.

A further point was made that, in some cases, the resistance can be too great and that effort is better applied in other areas or with other people. Sometimes, it was said, people resist change when they are asked to change, but willingly come along later, ‘in their own time’.

As already noted, it was seen as highly important to have respected clinicians, and clinical networks, to champion a desirable innovation and to help build the momentum for change. However, it was seen as equally important – particularly as the time for
implementation approaches - to have **executive support** or an ‘executive sponsor’. The point was made that actors in the system were more prepared to participate in some change process if they knew that the leadership of their organisation was supportive. Of course, the executive can also require people to play their role in the process and this can be a motivator for some. Having support from the Minister was thought to be ideal and that this “often generates a flurry of activity.”

It was noted that it was not sufficient to simply ‘get the okay’ of the LHD executive but that there needed to be some commitment on both sides. What was described was a process of asking the relevant executive to do certain things in support of the project (for example, making note of the project at an executive meeting, sending an email to relevant staff, attending a working group meeting) and making commitments to support them in that process in whatever ways necessary:

“It’s about getting someone in a position of power to care and then contracting with them about what things need to change and how.”

It was thought to be highly useful to prepare a **stakeholder engagement and communication plan**, or at least to think very strategically about how the engagement occurs. Engagement is fundamentally about getting people to think or behave in a certain way. Thought needs to be directed towards who is best placed to convey the message, what communications channels can be used, when the communication should take place, who should be involved in discussions and so forth. As one person said:

“You need to take everyone on a mental journey – that’s very difficult when there are lots of people.”

A number of people said that there were times when it was very useful to have clinicians and administrators in the same room to discuss the project, air their concerns, look for solutions etc. In other instances, it was thought that this could be counterproductive. The point being made by informants was that there should be a focus on the outcome that is desired and thought directed to how interpersonal or inter-professional dynamics might help to enable or else inhibit the process. One person added that it was advisable to prepare well for meetings to discuss new projects and to properly brief participants beforehand so that the meeting would lead to outcomes rather than being a ‘talk fest’:

“It’s important that we’re on the same page before we get there.”
A couple of people noted that engagement was often a subtle process that did not rely on explicit ‘calls to action’. Particularly in preparing for some change, or in trying to generate support for a new initiative, it was thought to be possible to “weave the messages into the conversation” via peer-peer communications, reminder systems, academic detailing processes etc.

One informant thought that it was very useful to apply marketing principles to the introduction of a new initiative. The idea was to use a simple marketing message and branding – as you would with a social change campaign. This informant made the point that “our messages are sometimes too noisy” and that a well-branded initiative could be more readily embraced in the same way that a shopper automatically selects a particular brand from a shelf.

Of course, making funds available is another way of engaging people and many of those interviewed made the point that funded programs were much easier to promote than innovation projects with no funding attached. As a couple of people said:

“Funding makes a difference…it can certainly help to prioritise and initiate change.”

“[Funding] Takes some of the heat off the matter.”

Interviewees made the distinction here between those change processes where individuals and organisations were required to implement some change (for example, because they were funded to) and those processes where they are asked to change because there are good reasons to. Many people noted that the work of ACI was particularly difficult because it is not able to mandate or fund LHDs and others to participate in change projects – engaging the right people is made more difficult but is also of more importance if the desired change is to be brought about.

A number of respondents also spoke of the attributes of change agents as being an important determinant of whether there is strong take-up of an initiative. Individuals given the task of supporting the wider implementation of some innovation need to have the ability to use the approaches described in this report. These people need good influencing skills and to be able to maintain good working relationships with others. They need to be resilient and tenacious. It was also consistently noted that in the health sector, people needed to have credibility in the eyes of clinicians. As a couple of people said:
“You need good people who understand clinicians…people who have worked in the system…you need to be seen on the ground…you need to be practical, grounded and able to talk to clinicians in their language.”

“It's about personal relationships, interpersonal skills – getting people to champion ideas, to try to influence others.”

Lastly, it was noted that to effectively engage people in order to drive forward some innovation, it was necessary to speak with key people face to face. The point was repeatedly made that making physical visits to LHDs rather than relying on teleconferences helped greatly:

“Get out on the road, do education to clinicians…build a critical mass to push through service development.”

3.5 Implementation and supporting the change process

Of course, it is not enough to demonstrate a need, produce an effective solution and then get agreement to make change – there needs to be good implementation. Indeed, several informants noted that sometimes, even the most worthwhile and well-supported projects do not reach their full potential because of poor implementation.

Obviously good project implementation needs good project management tools. However, a number of people discussed the importance of taking a flexible rather than a mechanical approach to implementing projects in the health system. The point was made that it was counterproductive to rigidly stick to a project plan. Rather, it was thought that good implementation focused on outcomes rather than process and that continual adjustments needed to be made in light of emerging issues and responses. As one person quite succinctly put it:

“It's implementation, not installation.”

It was also thought to be important that implementation was not rushed. It was noted that there is sometimes political and other pressure to implement new initiatives quickly but that this could easily result in an initiative that was unlikely to result in the best outcomes. It was thought that this pressure should be resisted and that, again, the focus should be on outcomes, not on sticking to the timeline stated in some project plan.
Several people made comments along the lines of: “clinicians are not always the best project managers.” It was noted that clinicians can be very influential and very supportive but do not necessarily have the time or skills to drive change outside of their immediate sphere of influence. It was noted that the most successful change projects or processes occurred where there was **good support provided to clinicians** (or others) who were championing a new way of doing things.

> “You need to temper, lead, support and help them.”

> “You’ve got to do the mundane stuff…ease the load on others.”

> “It’s the small things you do.”

It was further noted that what was required was a delicate approach of ensuring that the project was progressing but supporting rather than directing the project (and it’s leaders). It was said that good projects appeared to be being led by the right people and had local governance arrangements but were strongly supported with the resources of central agencies (such as ACI):

> “Don’t own it but support it.”

> “Don’t show them how to suck eggs but just touch base every so often.”

> “They should do the communicating, but you can tell them what to say and when.”

> “You need to work with people who are making the change, but under the table.”

> “You have to take the bullets for the clinicians.”

> “You need to make their life as easy as possible.”

> “Someone needs to take on the work of collecting data, presenting the evidence.”

In thinking about small-scale initiatives that are to be ‘scaled up’ and implemented across other regions or across the State, benefit was seen in taking an **incremental approach**. Rather than attempting to roll-out an initiative concurrently across all LHDs, say, taking one or a small number of LHDs at a time and constantly demonstrating effectiveness and efficiency in different contexts was generally thought to improve outcomes across the board.
In this context, ongoing **evaluation** of the implementation process and the outcomes achieved was seen as extremely important. Asking questions about whether outcomes were achieved and why or why not was seen as crucial to the wider success of the initiative as well as for the larger effort to drive innovation in the health system. It was thought to be important to appreciate that change happens in different ways and for different reasons, leading to different results and that evaluation can help to understand what happened and why. The point was also made that evaluation results greatly helped to build the case for wider adoption of an initiative and that, importantly, as time goes on and circumstances change, the case for change can be strengthened and modified:

“The ecosystem keeps changing...you need to keep reframing the case for change.”

Incorporating evaluation activity into the implementation process was also seen as a way of keeping participants ‘on their toes’ and less willing to provide only ‘passive’ support for an initiative. It was thought that ongoing evaluation helped to make initiatives more sustainable in that the ongoing attention on outcomes led to sustained effort to achieve them:

“Immediate gains are important but so is long term sustainability.”

It was also noted that there is government-wide pressure to better evaluate the effectiveness and efficiency of its activities and investments. The point was made that better evaluation led to better decisions and that efforts to bring about change were generally made easier if evaluation was a strong component of the way projects were implemented:

“There are too many examples of investments where benefits can’t be demonstrated. The days are gone where anecdotal information is enough.”

### 3.6 Structures, strategy and the role of ACI

Much of the discussion with informants focused on individual projects and what underpinned successful development and implementation. However, the discussions also touched on the issue of what helped innovation and change in general; what the right conditions were for innovation and improvement to be a part of the natural way of ‘doing business’.
Firstly, it was noted that the right structures needed to be in place to ensure that innovations were identified, developed and promulgated across the system. In this regard, it was thought that it was important to have dedicated resources to drive and manage change processes rather than relying on health care delivery and management structures alone. As one person said: “being given the time and opportunity to think about how to bring about change – that makes a difference.”

Generally, those consulted thought that the existing organisational structure of NSW Health (ie the ‘pillars’) was appropriate, though the interviews did not focus heavily on this question. What was stressed was that, regardless of the structure, there needed to be good coordination across agencies if innovation and change was to be managed in an effective way:

“The pillars need to work together with good coordination…you don’t want multiple groups running overlapping agendas.”

Importantly, agencies such as ACI were thought to need very clear strategic direction to govern their activities, with activity always linked back to strategic intent and an operational plan. Furthermore, it was thought that the activities of change agencies needed to be clearly linked to overarching Ministry of Health and NSW Government priorities and strategies. It was thought that ACI had a clear role to play in acting as a conduit between policy makers and clinicians and managers in delivering on overarching strategy:

“Aligning clinician priorities with MoH priorities is the key…corralling enthusiasm.”

It was also noted that positive change came about through having continuity in organisational structure and sustained approaches to the work. It was said to be very difficult to plan and manage a comprehensive change program if there was constant reorganisation of resources. Further, it was noted that change happens slowly and that it takes time for innovation and change strategies to bear fruit:

“You have to maintain consistency in strategy and direction – don’t give up. It sometimes takes years for the outcomes to emerge.”

This said, it was also thought to be important to ‘get some runs on the board’ and to build credibility in the eyes of actors across the system. The research was not in any way an evaluation of the effectiveness of ACI, but some comments were made. Generally, there was pride among those working within ACI for the achievements made to date and a strong view that there was good potential for ACI to be very
effective in the long run. There were a few question marks, however, from some of those outside of the organisation, particularly in relation to the clarity of the strategy it was pursuing. For example, one person said: “I see more turbulence in the water than it flowing anywhere.”

The point was constantly made that innovation and change was allowed to happen through the appropriate channelling of resources. In a sector where ‘core business’ is the delivery of health care, the resources to pursue new initiatives can be scarce. Having dedicated resources to support innovation and change was crucial. Particular mention was made here of the roles of supporting clinical networks, conducting economic modelling and providing implementation support. Following is an illustrative quote:

“The ability to mobilise resources, like the economic modelling, is what allows change to happen.”

Having realistic expectations, was also thought to be important. Some informants stressed that there needed to be a good understanding – embedded in the organisational culture – of the realities of change management. For example, the principle of KISS (Keep It Simple Stupid) and the pareto effect (the 80/20 rule) were thought to be useful in underpinning the way the work is approached. It was also noted that there needed to be the political will to allow trial and error to occur because “that’s where innovation comes from”. As one person said:

“Appreciate that change happens incrementally – there’s a constant effort to improve. New initiatives will never be perfect, but they should be better than what was there before.”

A very strong theme in the research was the importance of prioritising change projects and processes. Many people noted that there was no shortage of good ideas and worthy innovations to pursue. While this is not in itself a bad thing, it can be difficult to manage. Several people discussed the paralysing effect of trying to advance too many projects; that LHDs and others can be overwhelmed by requests to participate in improvement projects, particularly where they cannot easily see which are the most important things to focus on. It was noted that this situation comes about, in part at least, by the fact that the initiatives in question are non-funded and voluntary. Funded projects necessarily go through a prioritisation process as there are only so many funds available (and from the point of view of administrators, if a project has funding attached it must be a priority). Other projects are not necessarily subject to the same scrutiny and the ‘prioritising’ gets done at the coal-face rather than centrally.
It was repeatedly suggested that ACI needed a stronger framework for prioritising the innovations that emerged from the clinical networks and elsewhere (though it was noted that one was under development). Further, it was suggested that the clinical networks needed to work harder to prioritise the projects that they wanted to take further. A clear, transparent prioritisation framework was thought to have the potential to ease the burden on LHDs, to help individuals and organisations better see the links between the project and wider strategy and to ward off pressure to advance particular projects due to political and other influences. Following are some quotes to illustrate these themes:

“There’s too much competition for ideas.”

“If there’s a sense that initiatives aren’t being prioritised, it’s easy to just say no.”

“Choose a handful of things, tick them off then move on.”

“There needs to be more transparency around how decisions are made about how to use scarce resources. ‘Indecent decisions’ can be made just because there is money available.”

In thinking about the structures that allow for the successful development and adoption of improvement projects, the centrality of the clinical networks, institutes and taskforces was repeatedly acknowledged. It was noted that the networks provide an important conduit between clinicians and government that allows for innovation to be surfaced and for innovation (along with government priorities) to be acted upon.

However, it was also noted that the clinical networks, institutes and taskforces of the ACI have been developed in a highly organic fashion. The character of each is reflective of: the areas of practice/disease states in question; the professional groups involved; the personalities of the individuals involved; the power relations that exist; and the way in which they have been supported. One person said: “some of them are like interest groups, others are almost an accrediting body.” In short, it was said that while the clinical networks, institutes and taskforces of the ACI are central, the role they play varies from one to the next.

It was noted that coordinated programs of change were brought about by: empowering networks; helping them to build their credibility and influence; channelling the expertise that networks possess; and supporting them in their endeavours to bring about positive change. The role played by network, institute and taskforce managers is crucial and it was clear from the interviews that the role is a delicate one. These managers must provide practical support and access to resources. At the same
time, they need to channel the passion and enthusiasm of participants and endeavour to use their influence to bring about change within their field of practice.

It was clear from the interviews that network, institute and taskforce managers (and by extension ACI) were at the centre of the usual tensions between clinicians, administrators and policy makers. Their activities were often about balancing the desire to bring about good health outcomes, make services more efficient and to manage stakeholder interests. Although the issue was not explored through all of the interviews, some informants questioned whether ACI always struck the right balance here. The question was asked as to whether patients and the NSW community were always central to the way the organisation acted:

“There’s a tendency to focus on keeping clinicians happy rather than on patient outcomes…there comes a time when clinicians have to be pulled into line, but they’re tough conversations to have.”
4. CONCLUDING REMARKS

It was clear from the research that, among respondents, there was enormous clarity around what underpins successful and sustainable ‘up-scaling’ of innovative initiatives. There was also consistency, between those working within ACI and those working in other settings/jurisdictions, in relation to the questions of what enables and inhibits the process of ‘up-scaling’ innovation. There are certain principles to be kept in mind, that if embedded in the approaches taken by ACI and its staff, can give innovative initiatives the best chance of being adopted and having the desired impact. The research identified a number of broad factors that underpinned the successful and sustainable ‘up-scaling’ of innovative initiatives:

- a sound business case or ‘case for change’
- good preparation for the change process and thought given to how the initiative could be adapted to different contexts
- good engagement of clinicians, administrators and others
- good support provided through the implementation phase
- the right structures and strategies being in place to coordinate the implementation of innovation across the system.

This said, there is no instruction manual or ‘recipe book’ that can describe the steps that need to be taken to implement change. There was strong recognition of the fact that the health system is made up primarily of people who are not always rational or predictable. The difficult process of bringing about behaviour change, including among those who are resistant, is key to success and can not be approached in a step-wise fashion. The effectiveness of change agents depends heavily on their influencing skills and their ability to corral the support and involvement of those who can influence others.

It also needs to be acknowledged that each initiative is unique in terms of its benefits and drawbacks and the vested interests at play. There is always a unique set of factors and subtleties that establish a context in which the change is trying to be brought about – geographic, political, temporal and interpersonal. The challenge of wrestling with these contextual factors is significant and makes the practice of supporting change more an art form than a science. In short, the work of ACI needs to be guided by a sound strategic framework, but also handled deftly and in a way that always acknowledges system complexities.

It was also widely acknowledged that credibility was all-important and that the right structures need to be in place to coordinate innovation and improvement activities.
Prioritising activity within a clear strategic framework and making this transparent to stakeholders greatly helps to gain the widespread support of relevant individuals and organisations.

The discussions held with stakeholders did not provide the opportunity to critically reflect on how ACI goes about its business or how it is positioned within the NSW health system. However, this report on the views of stakeholders does provide valuable stimulus that could and should be used in future processes of reflection and strategic planning. The set of principles identified in this report also establishes a framework within which the processes and practices used to drive current and future change projects can be evaluated.
APPENDIX: INTERVIEW GUIDE
Introduction and background

ACI has embarked on a research study to better understand the complex interplay of factors that influence the way in which new evidence-based, quality and safety initiatives are promulgated within a large and complex health system and lead to sustainable, widespread change. This is referred to as Large Scale Transformation or LST. The research involves: a pragmatic synthesis of the published and grey literature of the key principles and mechanisms for supporting LST in health care; and a series of semi-structured interviews with senior researchers, policy makers, health managers, health practitioners and change agents. ACI has engaged Inca Consulting to conduct these interviews.

1. Could I start by asking a bit about your background and the role you play within this organisation?

Genesis of ideas

2. I want you to imagine that within an individual health organisation, a small group of practitioners or researchers have trialed a new approach to managing patients with a particular condition or who are at risk of developing a particular condition. Their work leads them to believe that the approach they have trialed is better than current practice – either in terms of better quality or safety, or because it makes more efficient use of available resources. There would be many steps involved in taking that initiative and seeing it implemented across the NSW health system – what are these steps?

3. Of course, there needs to be clear evidence of patient and/or health system benefit before there is any consideration of replicating an initiative elsewhere. But what is important with respect to the evidence and how it is presented if it is to underpin efforts to scale up the initiative?

4. Assuming that the evidence clearly demonstrates significant benefits (in the ways you have just described), what are the next steps? How does the initiative come to be seriously considered for wider implementation?

5. How do good initiatives, with the potential to be implemented more widely, come to the attention of decision makers? How are ideas shared between organisations within LHDs, across LHDs and across other jurisdictions? Are these information flows effective? What gets in the way?

6. Are there ways to improve the mechanisms for ensuring that good ideas come to the attention of decision makers?
Implementation

7. Does it make a difference who drives the implementation of some change process, whether it be government, clinicians (collectively or individually), consumer groups, administrators? How do these differences manifest themselves?

8. Can you think of an initiative that has been introduced in a health organisation, or across a region, where the implementation has been particularly successful? What were the characteristics of that process that made it successful? What were the contextual issues that needed to be considered (political, cultural, financial, clinical)?

9. Can you tell me about an initiative that was less-successfully implemented? What mistakes were made?

10. With these examples in mind, what are the important ‘ingredients’ of the successful implementation of new initiatives, systems, guidelines etc? When and which contexts are these things more (or less) important? AS REQUIRED PROBE EACH OF THE FOLLOWING [FROM THE LITERATURE]
   a. A good stakeholder engagement strategy
   b. Shared responsibility, distributed leadership
   c. Attending to history – adopting good practice and avoiding known pitfalls
   d. Good feedback loops, using appropriate measures of progress and impact
   e. Involving patients and families, putting the patient at the centre
   f. Striking the right balance between maintain the fidelity of the proven approach and allowing flexibility in delivery
   g. Engaging clinicians and having champions
   h. Good project management
   i. Having adequate resources available (people and infrastructure).

11. I’d like to talk now about implementation – how new initiatives are introduced to the NSW health system and what challenges must be addressed. Are there different approaches that better suit the particular type of change being implemented, e.g., a new model of care, new practice guides, new communication/referral protocols, new screening and assessment processes, new information systems or new integration of services? (this is about the product / type of change)
12. Are there important differences with respect to the likely challenges that an implementation might be faced with, e.g., based on the complexity of the initiative, whether the process is new or whether it affects rural communities? (this is about the variables that may influence the change)

13. What incentive structures could be established to support implementation, e.g., performance agreements, new funding models? (this is more about incentives of the super structure of the health system)

14. What are some of the common pitfalls and challenges in implementing change in NSW health organisations/regions/systems?

15. How can good practice in the implementation of new initiatives be engendered?

**Sustainability**

16. Once new initiatives are implemented, or change brought about, there is the issue of how these changes can be sustained. What are some of the lessons that have been learnt here? What are the challenges in seeing that change ‘sticks’ without the resources dedicated to implementation?

**The role of ACI**

17. What are the two or three things that need to be done better in the NSW health system to see the successful and sustainable implementation of large scale transformations?

18. How would you describe the work of ACI and how ACI is currently performing its functions to influence improvements across the system?

19. How could ACI improve? What strategies do you think ACI should adopt to maximise improvements across the system?

20. In summary, how can ACI improve its delivery into the future? Where should the focus be?