ACI Centre for Healthcare Redesign

Surgery Redesign Training Program: Evaluation Report

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1. Executive Summary

1.1 Background

The Surgery Redesign Training Program (the Program) is a five day course focused on the development of project management, change management skills and clinical redesign methodology. A total of 63 participants have attended four iterations of the Program between 2011 and 2013. Participants are front line clinical and managerial staff from NSW surgical services, nominated as project leads and/or project team members responsible for the implementation of surgical models of care or improving operating theatre efficiency at a local level. At a cost of approximately $16,000 per Program, a formal evaluation was undertaken to validate the recurring investment by the Agency for Clinical Innovation (ACI) in delivering the Program.

1.2 Methodology

The evaluation was carried out between 14 October and 6 December 2013 and involved:

- Interviews with 17 participants, 7 of the 24 Local Health District (LHD) and Specialty Health Network (SHN) Redesign Leaders associated with the Program, 8 project sponsors and 4 key lead agency staff
- A web-based survey capturing feedback from 37 participants
- A web-based survey capturing feedback from 18 LHD/SHN Redesign Leaders
- An audit of existing documentation including Program evaluations
- Collection of an illustrative case study
- Analysis of existing quantitative data including participant feedback.

Kirkpatrick’s four level model of evaluation (Kirkpatrick & Kirkpatrick, 1996, 2013) was used as a sequenced approach to assessing the effectiveness of training programs, measuring the reaction, learning, behaviour change and organisational results gained by participants as a result of the Program.

1.3 Main Findings

The Program achieves significant learning and skills development from a participant perspective, with lower scores on the effectiveness of learning and application of knowledge and skills from the perspective of Redesign Leaders and project sponsors. Participant skills consolidation is dependent on applying the methodology to deliver a project, thus achieving level three behavioural outcomes is closely aligned to level four organisational results.

Coaching by local Redesign Leaders is pivotal to translating the participant’s knowledge into behavioural change and organisational results. In addition, successful project completion leading to service improvement is dependent on participant selection, preparation and project resourcing. Currently, 25% of reported projects have been fully implemented, while 33% have not progressed beyond the initial planning stages.

The opportunity to successfully apply the knowledge, attitudes and skills learned to deliver project outcomes requires:

+ realistic project scope and timeframes
+ allocated time during work hours to progress the project
+ engagement of a strong local leadership body
Additional benefits of the Program are medical clinician engagement in service redesign, cross-discipline learning and networking, as well as fostering an open and supportive culture for NSW surgery.

1.4 Recommendations

Recommendations for Program improvement were offered by stakeholders throughout the evaluation. These recommendations were added to suggestions raised by a representative group of stakeholders at a solutions workshop held in December 2013. These recommendations focus on five main areas:

1. Improvements in the structure, content and delivery of the Program
2. Defining the governance, accountability and reporting structures for the Program at ACI and LHD/SHNs
3. Outline a robust process of participant and project selection and preparation
4. Proactive promotion of the Program in LHD/SHNs using the three part model outlining what, how and who (see diagram below)
5. Continuous improvement of the Program to align with the needs of LHD/SHNs through regular evaluation of participant experience, skills and project outcomes.

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**Diagram:**
- **What:** Set expectations, Build knowledge, Achieve project outcomes and organisational results
- **How:** Preparation (Project and participant work up), Program (Foundational knowledge and skills development), Support and resources (Skills consolidation and implementation experience with continued Redesign Leader coaching. Sponsorship through defined governance framework)
- **Who:** LHD/SHN, ACI, LHD/SHN
2. Introduction

2.1 Background

The Surgery Redesign Training Program (the Program) is a five day training and development course, first delivered in November 2011. The Program has run a total of four times between 2011 and 2013. Originally managed by the Health Services Performance Improvement Branch of the NSW Department of Health, the Program is now administered through collaboration between the Centre for Healthcare Redesign as part of the Agency for Clinical Innovation (ACI), the Surgery, Anaesthetics & Critical Care Portfolio (ACI) and the System Relationships and Frameworks Branch of the NSW Ministry of Health.

The Program was initially designed in response to the Surgery Futures Report (2010), which recommended the development of specialised training for Nursing Unit Managers (NUMs) in Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to implement new models of care specific to the surgery setting. The Program’s focus has since transitioned from the implementation of a model of care to the process of delivering an entire project.

The Program focuses on developing project management and change management skills, and introduces clinical redesign methodology (see Appendix 9.5). Two days of Accelerated Implementation Methodology training are also included.

Associated costs are approximately $16,000 per Program. The majority of this outlay is venue hire and catering. LHD/SHNs cover the cost of participant travel and accommodation. This figure does not include the time of the Program facilitators or presenters.

Participants are nominated to attend the Program by their executive manager. A specified workplace improvement project and project sponsor are pre-requisites for attendance. Preference is given to applicants whose projects focus on surgery specific issues, including improving theatre efficiency, first case on time start and achieving National Elective Surgery Targets (NEST).

Thus far, a total of 63 participants have attended the Program. Minor changes in the delivery of the Program have been made in response to participant feedback, including the use of a nomination form, access to an e-learning program to support continued learning, fortnightly follow-up teleconferences with the Program facilitators and increasing support from local Redesign Leaders.

2.2 Purpose of the Evaluation

The lasting impact of the Program on the skills and behaviours of the participants is currently unknown. The rate of successful implementation of projects led by participants of the Program also requires assessment. It is imperative a formal evaluation is undertaken to validate the recurring investment by ACI in delivering the Program. This evaluation is an ideal juncture at which to reassess the purpose, objectives and target audience of the Program, and to ensure the format of the Program aligns with expected outputs. This evaluation will inform the possible transferability of the Program format to support redesign capability development in other clinical settings.
2.2.1 Aim
To answer the following primary evaluation questions:

1. How has the Surgery Redesign Training Program impacted participant’s self-reported learning, reflected in knowledge, skills and attitude, and the application of these skills in the workplace?

2. Has there been successful implementation of surgery redesign projects at a facility and District level? How has the Program supported this?

2.2.2 Audience
This report is designed to facilitate the ACI Executive in making informed decisions regarding the future shape and direction of the Program and to inform LHD/SHN decision making on the use of the Program.

2.3 Comparison with Centre for Healthcare Redesign Diploma Program

<table>
<thead>
<tr>
<th>Redesign Diploma Program</th>
<th>Surgical Redesign Training Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>20 weeks active (52 weeks support total)</td>
</tr>
<tr>
<td><strong>Delivery mode(s)</strong></td>
<td>Face to face, GEM e-learning, independent learning, coaching, teleconference</td>
</tr>
<tr>
<td><strong>Dedicated project time in workplace</strong></td>
<td>Three days per week (minimum)</td>
</tr>
<tr>
<td><strong>Sponsorship</strong></td>
<td>Sponsor engagement prerequisite for attendance and maintained through formal processes</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>1. Professional development of the participant in understanding and applying project management and redesign methodology to innovate healthcare 2. Delivery of a redesign project of strategic priority for the health service 3. Development of the NSW Health workforce's capability to lead redesign projects</td>
</tr>
<tr>
<td><strong>Deliverables</strong></td>
<td>Six phases of assessment including e-learning quizzes, presentations, A3 reporting and requirements of the Diploma as per Aurora accrediting agency.</td>
</tr>
<tr>
<td><strong>Length</strong></td>
<td>20 weeks active (52 weeks support total)</td>
</tr>
<tr>
<td><strong>Delivery mode(s)</strong></td>
<td>14 face to face days, GEM e-learning, independent learning, coaching, teleconference</td>
</tr>
<tr>
<td><strong>Qualification</strong></td>
<td>Diploma of Project Management.</td>
</tr>
</tbody>
</table>

2.4 Methodology
The evaluation was carried out between 14 October and 6 December 2013. It includes elements of both formative and summative evaluation approaches.

The evaluation spans the entirety of the Program’s history. While changes have been made during this two year period, they have been relatively minor.

The mixed methods evaluation involved:
• Interviews with 17 of the 63 previous participants of the Program, 7 of the 24 LHD/SHN Redesign Leaders associated with the Program, 8 project sponsors and 4 key ACI staff
• A web-based survey capturing feedback from 37 previous participants (59% response rate)
• A web-based survey capturing feedback from 18 LHD/SHN Redesign Leaders (75% response rate)
• An audit of existing documentation including evaluations
• Collection of an illustrative case study
• Analysis of existing quantitative data including participant feedback

Detailed information on the evaluation methodology, including evaluation tools, is found in Appendix 9.2-9.4.

3. Description of the Surgery Redesign Training Program

3.1 Purpose

The Program was originally designed in response to the Surgery Futures Report (2010). This report recommended the development of specialised training for Nursing Unit Managers (NUMs) in LHD/SHNs to support the implementation of three new models of care specific to the surgical setting. LHD/SHNs were allocated funding by NSW Health to implement these models.

The Program now functions as a capability building tool, a mode of quality improvement and professional development, and as a means of fostering a supportive culture and community of practice for NSW surgery services. The aim, goals and objectives of the Program have evolved over the past two years, and have not yet been explicitly updated.

3.2 Governance

The Program is currently administered through a partnership within the ACI between the Centre for Healthcare Redesign and the Surgery, Anaesthetics and Critical Care Portfolio, including the Surgical Services Taskforce, as well as the System Relationships & Frameworks Branch of the NSW Ministry of Health. These three bodies contribute human resources and financial support to the Program.
3.3 Key Roles - the current state

Program participants
Participants are front line clinical and managerial staff from surgical services across NSW who are nominated as project leads and/or project team members responsible for improving surgical services at a local level. 19% of participants attended the Program as part of a project team. LHD/SHNs are encouraged to send participants to the Program with a specific project to implement. 84% of participants attended with a specific project. Attendance at the five face to face training days is the only requirement for successful completion of the Program.

On return to the workplace, participants are strongly encouraged by the Program facilitators to:
- Connect with their local Redesign Leader
- Submit a project plan to the Program facilitators in a timely manner.

To achieve project outcomes, the project team is expected to follow project management, clinical redesign and Accelerated Implementation Methodology (AIM), with the support of their organisation. Further interaction with the Program facilitators is optional.

Project sponsor
The project sponsor’s role is to nominate staff to attend the Program and authorise, legitimise and demonstrate ownership for the project at an executive level. Project sponsors are not...
directly involved in the Program. As such, it is expected that the Redesign Leader and the project sponsor work with the project team to ensure there is allocation of appropriate resources to suit project objectives and timeframes.

Redesign Leaders
The NSW Redesign and Innovation Network consists of 27 experts in project and change management across all LHD/SHNs. Permanent funding for these roles was established in 2011 with recruitment to unfilled positions commencing in early 2012. The purpose of these roles is to support capability development in redesign at the local level and coach those who have attended training in redesign. Every LHD/SHN had recruited a Redesign Leader by November 2012. Redesign Leaders have played an increasingly active role in supporting the Program, however each Redesign Leader’s contribution to the Program, the participants and their projects varies according to local practices. In general, Redesign Leaders:

- Contribute to the process of identifying optimal projects and participants to attend the Program. 39% of Redesign Leaders are currently involved in the selection process for the Program in their local LHD/SHN
- Coach and support participants to implement their project using the methodology. 76% of Redesign Leaders have coached a participant of the Program while they worked on their project
- Contribute directly to the Program by delivering sessions to the participants during the five days of face to face learning. Four Redesign Leaders delivered sessions at the most recent Program in May 2013
- Facilitate networking within and across clinical and geographical boundaries. 29% of Redesign Leaders have facilitated networking of participants within their LHD/SHN.

Program facilitators
There are two key Program facilitators who organise and run the Program. These facilitators are AIM practitioners with strong backgrounds in surgery, and are supported by the Centre for Healthcare Redesign and Redesign Leaders to create:

- A challenging experience where participants learn and develop awareness and capabilities in redesign, change and project management
- An opportunity to learn from and be coached by recognised experts in the redesign and theatre management fields
- A learning culture supported by coaching and online educational resources
- Opportunities for knowledge transfer.

ACI sponsors
The directors of the ACI Clinical Program Design and Implementation Portfolio and Surgery, Anaesthetics, & Critical Care Portfolio fund the delivery of the Program as part of ACI strategic plan to partner with LHD/SHNs to support the implementation of efficiencies and new models of care, and to support capability building in clinical redesign, specifically from a surgery perspective.

3.4 Application and Selection Process
An Expression of Interest (EOI) letter is sent by ACI to the Chief Executives of all LHD/SHNs approximately six weeks prior to the Program commencing. The EOI outlines the purpose and requirements of the Program and asks for the nomination of a local project lead to attend. A nomination form is completed, outlining the details of the project, identifying the project sponsor and must be signed off by a senior executive. Participants with projects that relate to
theatre efficiency, first case on time start, achieving National Elective Surgery Targets (NEST) or the management of fractured hip patients are given priority to attend. To date, all applicants have been accepted into the Program. There is no pre-requisite training or preparation required and occasionally participants attend without a project or nominated project sponsor.

3.5 Content and Structure
The Program content introduces clinical redesign methodology and AIM, underpinned by project management methodology tools and skills. The course structure focuses on applied learning, taking participants through the methodology step by step. Time is provided during the sessions for participants to complete sections of their project plans. Titles of sessions include:

- Enhancing the Patient Experience
- Risks and Issues
- Presentation Skills
- Data Sources, NEST and Data Dictionary
- Data Analysis
- Cost Benefit Analysis
- Theory of Constraints

The timetable from the May 2013 Program is found in Appendix 9.1.

3.6 Delivery
The Program is delivered face to face in a classroom style over five consecutive days, through interactive presentations from internal experts on redesign, theatre management and project management.

3.7 Post-Program Support
Since 2012, formal post-Program support has been offered by the Program facilitators through fortnightly teleconferences. These teleconferences had low levels of attendance and were cancelled due to lack of attendees. When participants return to work, the experience of leading and implementing a project occurs using local support structures, and is preferably facilitated by the local Redesign Leader.

4. FINDINGS (1): Assessment against Kirkpatrick’s Four-Level Training Evaluation Model

4.1 Introduction
Kirkpatrick’s four level model (Kirkpatrick & Kirkpatrick, 1996, 2013) was used for this evaluation as it is a well-recognised evaluation method that has been widely used over a number of decades across most industries, including health. The Kirkpatrick model was used to assess the Centre for Healthcare Redesign Diploma Program in 2013.

The four levels of Kirkpatrick's model represent a sequenced method of evaluating the effectiveness of training programs. The four levels are:

- Level 1: Reaction. What did participants think and feel about the training event?
Level 2: Learning. Did participants acquire the intended knowledge, skills and attitudes from their participation in the learning event?

Level 3: Behaviour. Did participants apply what they learned when back on the job?

Level 4: Results. Were outcomes achieved for the organisation as a result of the learning event?

4.2 Participant Reaction

To assess participant reaction, the learning event is defined as the experience of the five day face to face Program. Participant reactions to the Program were sought at the end of each day of training for three of the four iterations of the Program, using a paper based survey. To supplement this, information on the participant reactions to the training Program has been collected from a variety of sources including i) an online survey of participants ii) interviews with participants. Clear convergence of results was found across these sources, with strong evidence that the participant reactions to the Program over the last two years have been very positive.

The paper based survey completed by participants immediately following the conclusion of the most recent Program in May 2013 (n=12, 67% response rate) showed 86% were satisfied with the course overall and 86% agreed that the teaching/presentation style was effective. Responses to the Program held in December 2012 were exceedingly positive (n=15, 100% response rate) as 93% of participants were satisfied with the course overall and 94% said the teaching/presentation style was effective.

The web-based survey combined responses from participants from all four iterations of the Program. Responses to this survey (n=36, 57% response rate) show 100% satisfaction with the Program overall, with 94% agreeing that they would recommend the Program to others. 92% of participants found the Program a valuable networking opportunity, with 67% reporting that they have been in contact with one of more people they met through the Program to discuss a project or issue. The breakdown of responses to the web-based survey by participants is shown in Figure 2.

![Figure 2: Web-based survey results demonstrating participant reactions to the Program](image-url)
4.2.1 What worked well?
This positive response was reflected in the comments made during interviews with participants. Figure 3 summarises the factors that participants reported contributed positively to their learning experience. Themes that emerged included the high quality presenters and the benefits of networking.

<table>
<thead>
<tr>
<th>Level 1: Reaction</th>
<th>What worked well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Presenters of a high quality- ‘well run and well taught’</td>
</tr>
<tr>
<td>✓</td>
<td>Content ‘bridged gap between the metro/rural experience’</td>
</tr>
<tr>
<td>✓</td>
<td>Great venue, food and accommodation</td>
</tr>
<tr>
<td>✓</td>
<td>Appreciative of investment in professional development- ‘felt like a reward’</td>
</tr>
<tr>
<td>✓</td>
<td>Networking</td>
</tr>
<tr>
<td>✓</td>
<td>Group learning environment</td>
</tr>
<tr>
<td>✓</td>
<td>Opportunity to learn more about theatre processes and priorities</td>
</tr>
<tr>
<td>✓</td>
<td>Completing GEM e-learning modules prior to attending</td>
</tr>
</tbody>
</table>

Figure 3: Factors that positively influenced participant reactions to the Program

4.2.2 What didn’t work?
Factors that negatively influenced participant reactions to the Program are summarised in Figure 4. While these factors did not apply to all participants, themes that emerged from their comments in the web-based survey and interviews focus on feeling inadequately informed and unprepared for the commitment of leading a project. It is important to note that as an interactive learning experience, the Program sessions are designed to facilitate participants with a clear project in mind. Walking participants through the methodology and applying these learnings to document a project plan in the classroom was ineffective for the 16% of participants who attended without a specific project.

<table>
<thead>
<tr>
<th>Level 1: Reaction</th>
<th>What didn’t work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>Lack of preparation of participants- ‘I felt unprepared and overwhelmed’</td>
</tr>
<tr>
<td>✗</td>
<td>Late notification of attendance (&lt; 1 week)</td>
</tr>
<tr>
<td>✗</td>
<td>Unclear project objectives and expectations- ‘I wasn’t really sure what I was supposed to be doing...’</td>
</tr>
<tr>
<td>✗</td>
<td>Participant selection. Some felt unsure they were in a position to implement changes required</td>
</tr>
<tr>
<td>✗</td>
<td>‘Intensiveness of 5 days was draining’</td>
</tr>
</tbody>
</table>

Figure 4: Factors that negatively influenced participant reaction to the Program

4.3 Participant Learning
The Program’s three main learning goals, gleaned from the content of the Program and interviews with the Program facilitators are:
1. To acquire knowledge related to clinical redesign, project management, implementation and efficiency improvement in the perioperative setting
2. To learn new skills and/or increase present skills
3. To foster a positive attitude to clinical redesign

Assessing the learning that has occurred as a result of the Program against the learning objectives will reveal the effectiveness of the Program in achieving a level 2 outcome for participants. Questions in the web-based participant survey targeted the perceived acquisition of relevant knowledge, skills and attitudes. In regard to assessing attitudes, 89% of participants said they have changed the way they think about change processes and 86% have changed the way they think about clinical redesign. The shift in participant thinking about change and clinical redesign is likely positive, in line with positive responses to their experience of the Program.

![Figure 5: web-based survey results demonstrating self-reported learning](image)

Over 90% of previous participants agreed that the Program made a significant contribution to equipping them to implement change and to manage projects to improve healthcare delivery (Figure 5); two key aims of the Program.

When questioned about the main learnings they gained from the Program, a range of topics were mentioned by participants including:

- “Learning a proven methodology for implementing change
- How to effectively manage a project
- Change management
- Clinical redesign
- Networking with peers from other areas with different projects
- Writing and using a business case
- Where to look for data and how to use it”

These areas are consistent with what the Program facilitators considered to be the main learnings from the Program.

Figure 6 highlights the effectiveness of the Program in imparting relevant knowledge and skills in project management, clinical redesign and change management in more detail. Participants were asked to rate their current skill level in each element of the main learning
areas of the Program. On average, 62% of participants reported that they possessed the
skills to independently lead a project and 94% said they had the skills to lead a project with
assistance. Participants felt most skilled in communication with project stakeholders, followed
by engaging and managing a project sponsor and diagnosing the root cause of a problem.
Participants were least confident in data sourcing and analysis and designing solutions to a
problem.

In light of your experience at the Program, please rate your current skill level in...

![In light of your experience at the Program, please rate your current skill level in...](image)

**Figure 6: Self-rated skill level after attending the Surgery Redesign Training Program**

In comparison to Figure 6, Figure 7 shows Redesign Leader’s expectations of participants
following their attendance at the Program. Only 6% of Redesign Leaders expect participants
to have the capacity to fully implement a redesign project and just over half agreed that
participants would have the capacity to implement a project with their assistance. Redesign
Leaders and participants had different perceptions of the successful acquisition of knowledge
and skills as a result of attending the Program. This gap is clearly expressed by only 35% of
Redesign Leaders expecting participants to have knowledge and skills in change
management and apply these skills to their work environment, in contrast to the 62% of
participants who feel they possess the skills to implement a project independently. This is
likely due to the in-depth knowledge and experience of Redesign Leaders in the areas of
clinical redesign and project management in comparison to participants. This gap also
demonstrates the significant volume and quality of knowledge gained during the Program
from a participant perspective.
4.3.1 What worked well?

The web-based survey results are illustrated by participant and Redesign Leader interviews. Figure 8 summarises the factors that participants reported contributed positively to their acquisition of knowledge, skills and attitudes in the areas of clinical redesign, project management and implementation. Thematically, teaching a practical methodology to manage and implement change and attending as part of a mixed discipline/specialty team were reported by all respondents as enhancing knowledge and skills development.

<table>
<thead>
<tr>
<th>Level 2: Learning</th>
<th>What worked well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Methodology- giving practical steps to follow</td>
</tr>
<tr>
<td>✓</td>
<td>Big picture/systems focus</td>
</tr>
<tr>
<td>✓</td>
<td>Completing GEM e-learning modules prior to attending Program</td>
</tr>
<tr>
<td>✓</td>
<td>Using a laptop to write project plan/business case during the Program to utilise expertise in the room</td>
</tr>
<tr>
<td>✓</td>
<td>Attending as part of a mixed discipline/specialty team</td>
</tr>
<tr>
<td>✓</td>
<td>Information booklet useful as a resource- ‘I still use it like a textbook’</td>
</tr>
<tr>
<td>✓</td>
<td>USB with takeaway information, templates and resources</td>
</tr>
<tr>
<td>✓</td>
<td>Teaching resilience- ‘I learned that if a project fails, you re-evaluate and start the process again - no work is wasted’</td>
</tr>
</tbody>
</table>

Figure 8: Factors that positively influenced participant learning from the Program

4.3.2 What didn’t work?

Redesign Leaders and participants identified several areas which negatively impacted the acquisition of knowledge, skills and attitudes. These adverse factors spanned the breadth of the Program, from lack of pre-Program preparation to negative experiences of follow up on
project progress once participants returned to the workplace. Figure 9 shows the themes that emerged from interviews regarding barriers to effective learning.

<table>
<thead>
<tr>
<th>Level 2: Learning</th>
<th>What didn’t work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>×</td>
<td>Unclear project objectives reduced the effectiveness of the Program structure and delivery</td>
</tr>
<tr>
<td>×</td>
<td>Follow up teleconferences</td>
</tr>
<tr>
<td>×</td>
<td>Few used GEM e-learning modules</td>
</tr>
<tr>
<td>×</td>
<td>Lack of local accountability and reporting in place to secure knowledge and skill development</td>
</tr>
<tr>
<td>×</td>
<td>Structure- ‘five days is not enough time to impart all information’</td>
</tr>
<tr>
<td>×</td>
<td>Arbitrary reporting milestones imposed by ACI</td>
</tr>
<tr>
<td>×</td>
<td>Culture change and managing resistance to change remained a challenge when participants returned to work.</td>
</tr>
</tbody>
</table>

Figure 9: Factors that negatively influenced participant learning from the Program

The fortnightly follow up teleconferences were not well attended. Participants reported not these teleconference as they felt they had sufficient support from their Redesign Leader and the Program facilitators directly, or said that they had no progress to report. These teleconferences were ceased within months of the conclusion of the Programs due to lack of attendance.

Participants who were required to give regular project updates at a local executive level were more likely to have successfully completed project milestones. This was due to recognition that the project needed governance at an organisational level and regular reporting of project progress. Redesign Leaders also identified that participants who did not use their newly developed knowledge and skills soon after returning to work (within ~six weeks) were less able to consolidate their learnings, and thus had to spend more time refreshing their knowledge before they could progress their project.

Interviews with the Program facilitators revealed that imposing arbitrary reporting milestones as a method of follow up to encourage project completion was largely unsuccessful. The expectation that adding reporting timeframes would increase project outcomes was not realised, as participants reported this added an extra burden. This approach resulted in
- increased administrative duties for the Program facilitators in the form of fielding phone calls from participants to renegotiate due dates for reports
- a paradoxical power dynamic of accountability, where there was no avenue for ACI to hold participants accountable for failing to deliver reports as per the schedule
- pressure on participants and projects to reach milestones by set dates, regardless of local context and priorities
- a small number of participants abandoning their projects due to the stress of being unable to deliver reports on schedule.
4.4 Participant Behaviour

For the training to provide return on investment at a system level, participants must apply the knowledge, skills and attitudes they learned during the Program when they return to their work environment. This evaluation asked participants, Redesign Leaders and project sponsors to identify what change in behaviour occurred at work as a result of participants attending the Program.

The web-based participant survey demonstrates that the majority of participants report applying what they learned at the Program in their work environment. Figure 10 demonstrates that since returning to work, 83% of participants have led a project, 89% often use the skills and knowledge they acquired and 67% have transferred these skills to others. As reported in participant interviews, transfer of skills occurred across a number of levels; from participants coaching their team members or peers on project management and implementation methodology to applying their own skills to other smaller scale projects in the workplace.

Figure 10: Self-reported use of skills and knowledge since completing the Program

Redesign Leaders reported that the observed application of knowledge and skills in the workplace was varied. There was discrepancy in the perception of the application of diagnostic skills. 61% of participants felt they could implement the diagnostic phase of a project without assistance, while the majority of Redesign Leaders said diagnostic skills were generally lacking in participants on return to the workplace. Applying diagnostic tools is a significant component of the clinical redesign methodology however only three hours of the Program are devoted to teaching this knowledge and skill set.

Interviews with project sponsors (n=7) identified that 71% saw enhanced change management, planning or communication skills in the participant and 57% saw evidence of the use of a project management or redesign methodology.

4.4.1 What worked well?

When participants were asked what enabled the application of skills and knowledge in the workplace, the major recurring themes were active coaching by local Redesign Leaders, having allocated time to work on the project and returning to a community of practice. Figure 11 summarises information from interviews with participants and Redesign Leaders to
identify factors that positively influenced the application of knowledge and skills in the workplace.

<table>
<thead>
<tr>
<th>Level 3: Behaviour</th>
<th>What worked well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Redesign Leader support- <em>‘if it wasn’t for her (Redesign Leader), the project would have fallen through’</em></td>
<td></td>
</tr>
<tr>
<td>✓ Allocated time during work hours to progress on project</td>
<td></td>
</tr>
<tr>
<td>✓ Participant invested in outcome</td>
<td></td>
</tr>
<tr>
<td>✓ Support from and accountability to local Executive through enrolment in local leadership/professional development programs</td>
<td></td>
</tr>
<tr>
<td>✓ Steering Committee to maintain progress, momentum and share ownership of project</td>
<td></td>
</tr>
<tr>
<td>✓ Regular meetings with sponsor</td>
<td></td>
</tr>
<tr>
<td>✓ Pairing up with a local participant of the Redesign Diploma Program</td>
<td></td>
</tr>
<tr>
<td>✓ Returning to a community of practice</td>
<td></td>
</tr>
<tr>
<td>✓ Access to Clinical Redesign shared drive at a local level.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 11: Factors that positively influenced the application of knowledge and skills in the workplace

Linkages between Redesign Leaders and Program participants; from pre-Program preparation to regular meetings during the implementation phase enabled participants to successfully apply what they had learned. Both participants and Redesign Leaders agreed that Redesign Leader involvement was vital for maintaining project momentum and following the methodology correctly. Participant’s desire to move straight to the solution design phase was managed by the input and guidance of the Redesign Leaders. Currently, only 76% of Redesign Leaders have coached a Program participant while they worked on their project, and only 30% of LHD/SHNs reported an effective structure for connecting Redesign Leaders with Program participants. One District’s experience of the Program has been captured in the following case study.
Participants emphasised the need for allocated time during working hours to progress their project. While most managers recognised participants may need time to work on their projects, few provided the extra resources to allow for this during work hours. Figure 12 shows 47% of participants reported being able to work on their projects to a moderate or large extent while at work, while only 41% of Redesign Leaders agreed that participants were given the time and resources needed to successfully implement their project.

Case Study: a tale of three Surgery Redesign Training Program participants

This District has sponsored a total of three participants to attend the Surgery Redesign Training Program from 2012 to 2013. The Redesign Leader positions were filled in March 2012. At this time, there was no formal state-wide or local process for connecting Redesign Leaders with Program participants.

The first participant to attend the Program had no contact with the District’s Redesign Leaders, was promoted soon after attending the Program, and the project failed to progress.

The second participant was nominated to attend the Program by their manager. The Redesign Leaders were not aware of the Program occurring or that a participant from their District was attending. Four months after the Program, the Redesign Leaders were made aware of the second participant and asked to assist them. Coaching was offered and subsequently the Redesign Leaders assisted the second participant to write and submit their overdue project plan, create a timeline with milestones and negotiate with their manager for some allocated time to complete the project. The Redesign Leaders had not factored this project into their work plans. 12 months on, recommendations from this project are being implemented resulting in positive changes in Key Performance Indicators.

The third participant was nominated to attend the Program after discussions with their manager and the Redesign Leaders to scope the project and determine the required resources and timeframes. Pre-program preparation for the participant, with the Redesign Leaders, was limited due to pre-arranged leave by the latter. On return from the Program, the third participant met with the Redesign Leaders to establish project timelines. The ACI had set reporting timeframes for project deliverables for this particular program with the intention of promoting project progress. The project timelines set by ACI did not articulate well with the local project requirements, placing unnecessary pressure and workload on the participant and Redesign Leaders. In addition, the participant and Redesign Leaders report that there was little recognition from ACI of the deliverables. At a local level, the diagnostic from this project will inform a large scale service redesign scheduled for mid-2014.

This District has now implemented a process for selecting projects and participants to attend the Redesign Diploma Program and the Surgery Redesign Training Program which includes the Redesign Leaders and considers their capacity to support the participants with their projects. The learning and knowledge gained through these experiences has created a more robust approach to the Program which will assist in achieving better outcomes.
Participants who returned to a community of practice in their local facility or LHD/SHN were more likely to report successful project progress and application of knowledge and skills. In this context, a community of practice is supported by the local Redesign Leader and involves creating linkages between past and current participants of the Centre for Healthcare Redesign Diploma Program, the Surgery Redesign Training Program and other people who are experienced and interested in clinical redesign, project management and implementation methodology. While only 36% of Redesign Leaders say their District utilises people who have attended the Program to facilitate further local change management and/or clinical redesign processes, participants who were linked with other redesign students, experts and resources were better able to apply their knowledge and skills.

4.4.2 What didn’t work?

The lack of allocated time and local accountability structures for project reporting reduced the ability of participants to apply their knowledge, skills and attitudes in the workplace. Other factors which adversely affected application of new behaviours were the reliance on high quality writing skills of participants and the timing of the December Program, as outlined in Figure 13.

<table>
<thead>
<tr>
<th>Level 3: Behaviour</th>
<th>What didn’t work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>× Lack of allocated time to work on project</td>
<td></td>
</tr>
<tr>
<td>× Lack of accountability, follow up reporting and designated timeframes</td>
<td></td>
</tr>
<tr>
<td>× Assumptions regarding quality of Participant’s writing skills</td>
<td></td>
</tr>
<tr>
<td>× Holding Program in December- theatres are very busy and then shut down</td>
<td></td>
</tr>
</tbody>
</table>

In interviews, Redesign Leaders reported issues around participant’s writing skills. Project management and the implementation of methodologies rely on high quality written communication skills which are not currently featured in the Program content. Redesign Leaders provided a high level of assistance to participants to write professionally, persuasively and using sophisticated project language. This level of support became
particularly challenging when milestone reports were due, and Redesign Leaders had not factored this intense level of coaching into their work plans.

The timing of the December Program was also frequently raised by Redesign Leaders and participants as a barrier to skills consolidation and project progress. Theatres are generally busy in the lead up to the holiday period, followed by a low activity period of two to six weeks, with many key staff on leave. These conditions create a difficult environment to initiate a project, limiting opportunities for participants to consolidate their knowledge on return from the Program.

4.5 Organisational Results

The assessment of project results was challenging and reflected the perceived lack of clarity around project objectives and the definition of implementation by participants. The web-based survey asked participants to describe the current status of their project, as shown in Figure 14. Respondents (n=36, 59% response rate) said 25% of reported projects have been fully implemented and 33% have not progressed beyond the initial planning stages. This marginal implementation rate is supported by data from the Redesign Leader web-based survey, in which only 6% of Redesign Leaders identified that projects from the Program are often implemented, while 76% of Redesign Leaders said projects are only sometimes implemented.

![Participant's description of the current status of their project](image)

*Figure 14: Participant’s description of the current status of their project as at October 2013*

When interviewing project sponsors, it was important to acknowledge the range of acceptable timeframes for implementation. Thus, the evaluation question project sponsors were asked was ‘is the current progress of the project meeting your expectations?’ Responses to this are illustrated in Figure 15 (n=7). Projects failing to meet the expectations of their sponsor were behind of deliverables, while those projects that were somewhat meeting expectations were behind on timeframes.
4.5.1 Enhanced Workforce Capability

The Program has successfully enhanced workforce capability, as demonstrated by the relative success in achieving level 2 and level 3 results. This is reflected in the development and application of skills, knowledge and attitudes learned during the Program around project management, clinical redesign and implementation methodology. Many participants reported feeling more confident in their skills and enjoyed being recognised by their manager as having project management potential. Other enhancements to workforce capability include:

- ‘We fully implemented a new patient flow process, and introduced data collection practices. Everyone is happier’
- ‘Our First Case on Time went from about 20% to 60%’
- ‘We made great reductions in operating time, cancellation rates and improved our NEST. The efficiencies were able to pay for a weekend floor manager’
- ‘All of our theatre KPIs improved, particularly our utilisation out of hours’
networking, cross discipline problem solving and a greater understanding of the tools and resources available to support clinical redesign projects and processes at a local and system level.

4.5.2 What worked well?

Factors which supported the successful delivery of project outcomes are themed in Figure 17, and share many similarities with success factors for levels 2 and 3, as predicted by the Kirkpatrick model (1996). Crucial to successful implementation was regular reporting through a local accountability structure and Redesign Leader involvement. Associated NSW Health funding and other external impetus for change, including Ministry review of surgical services, also improved the probability of successful project delivery, presumably by increasing the priority of the project. Participants noted that local acknowledgement of quick wins by senior executives assisted in maintaining the momentum of the project and engagement of staff.

<table>
<thead>
<tr>
<th>Level 4: Results</th>
<th>What worked well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Redesign Leader support pre and post Program</td>
</tr>
<tr>
<td>✓</td>
<td>Pre-negotiated allocated time to complete project</td>
</tr>
<tr>
<td>✓</td>
<td>Report to a Steering Committee as an accountability structure- to maintain progress, momentum and share ownership</td>
</tr>
<tr>
<td>✓</td>
<td>Associated Ministry funding or other external impetus for change</td>
</tr>
<tr>
<td>✓</td>
<td>Projects with full support of managers, Exec and clinical leaders</td>
</tr>
<tr>
<td>✓</td>
<td>Clear expectations, timeframes and deadlines</td>
</tr>
<tr>
<td>✓</td>
<td>Mentoring/linking Redesign School participants with Program Participants- community of practice</td>
</tr>
<tr>
<td>✓</td>
<td>Local acknowledgement of successes</td>
</tr>
</tbody>
</table>

Figure 17: Factors positively influencing organisational results

4.5.3 What didn’t work?

Themes that emerged from interviews with participants, Redesign Leaders and project sponsors regarding barriers to organisational results are outlined in Figure 18, with a focus on unrealistic expectations of what the Program could deliver in terms of supporting project outcomes, lack of local linkages between Redesign Leaders and participants and sponsorship issues.

The absence of formal recognition or incentives for project deliverables was raised by Redesign Leaders and project sponsors as a possible barrier to skills consolidation and project implementation success, particularly in comparison to the Clinical Redesign Diploma Program. Both these stakeholder groups acknowledged that delivering a project is an intensely demanding experience for the participant and ideally this should be recognised locally and at a state-wide level.

Redesign Leaders noted that they were not consistently informed about staff from their District attending the Program, and thus did not always have the facilitation of the associated projects in their work plans. In some cases, this resulted in later than ideal contact with participants on return from the Program, stretched resources and rushed project phases.
Effective sponsorship at the right level of seniority was also raised as an issue by Redesign Leaders. Only 12% of Redesign Leaders agreed that project sponsors often understand and embrace their role. This is a particularly sensitive issue in the context of operating theatres, where senior medical, nursing and administrative sponsorship is key to successful behaviour change. Strong sponsorship from senior medical leaders e.g. the Director of Medical Services or Director of Surgery is not a targeted focus of the Program. 44% of participants reported that they had an effective sponsor for their project. There may be some disparity in views on the requirements of effective sponsorship.

<table>
<thead>
<tr>
<th>Level 4: Results</th>
<th>What didn’t work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>Lack of appreciation of difference between the Diploma Program and the Surgery Redesign Training Program</td>
</tr>
<tr>
<td>✗</td>
<td>Redesign Leaders not informed of projects or participant- unable to factor surgery projects into work plans</td>
</tr>
<tr>
<td>✗</td>
<td>Vague sponsorship</td>
</tr>
<tr>
<td>✗</td>
<td>Lack of DMS sponsorship</td>
</tr>
<tr>
<td>✗</td>
<td>Single participant attending from a large organisation with big project</td>
</tr>
</tbody>
</table>

Figure 18: Factors negatively influencing organisational results

4.6 Additional Benefits of the Program

*Increasing medical clinician and managerial redesign capability*

While the first iteration of the Program was designed for NUMs, the Program has evolved to cater for other professional groups. The short length of the Program has enticed an increasing number of surgeons and administrative managers to attend, usually as part of a mixed discipline project team. Figure 19 demonstrates growth in the number of surgeons and administrative managers attending the Program. This builds professional interdisciplinary networking and teamwork.

Figure 19: Participants of the Program by discipline
Medical clinician engagement
All doctors who attended the Program were approached to contribute to the evaluation. Interviews with two of the eight doctors who attended the Program highlighted the benefits of medical clinician engagement in clinical redesign and change management processes. Both participating doctors and the project sponsors spoke positively of the experience and application of the knowledge, skills and attitudes gained as a result of the training. One surgeon who attended the Program described her experience below:

“This was very eye opening for me as a surgeon. I didn’t know that we could make such a positive contribution to patients and our workplaces on a systems level. I’d really encourage all surgeons with an administrative element to their role to learn about opportunities for change and improvement which exist at every hospital. I used to think all surgeons could do was see their patients, operate and then go home, but there are many more opportunities to make a positive difference”

Executives who had acted as project sponsors for medical clinician’s projects were enthusiastic to send more medical clinicians to future Programs. Several sponsors reported that they plan to incorporate the Program and an associated project into the role of the Surgical Superintendent. The short length and freedom from externally structured reporting commitments were named as key reasons why the Program was preferred by doctors and some project sponsors to the Centre for Healthcare Redesign Diploma Program. All sponsors agreed that it was unlikely medical clinicians would feel able to commit to a 20 week Diploma Program.

Cross-discipline learning
Participants who attended from areas of the hospital outside of operating theatres e.g. ward NUMs and administrators, found learning about theatre processes and priorities informative and reported they felt better able to understand how to work with staff in the perioperative setting to improve the patient journey.

Networking
The networking opportunities provided by the Program were highly valued by participants and project sponsors alike. Interaction with colleagues from across NSW surgical services functioned as:

+ a morale boost and reminder that theatres across NSW face similar challenges
+ a reality check for theatre managers and staff where expectations of process efficiency and performance indicators are tested and validated
+ a supportive group learning environment
Fostering a positive and supportive culture for NSW surgery
The Program facilitators have used the Program to foster a NSW surgery culture and community of practice focused on communication, strong inter-professional relationships, collaboration and continuous quality improvement. The system level networking, as well as interaction with senior managers from the Ministry of Health and the ACI, supports surgery services to constructively debate issues and solutions, underpinned by a community of clinical redesign practice.

4.7 Variation in Expectations of the Program
The evaluation tested the respondent’s expectations of the purpose of the Program and found significant variation between stakeholders, as outlined in Figure 20.

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Perceived aim of the Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>‘give us a tool for projects- to explain the how and give support’</td>
</tr>
<tr>
<td></td>
<td>‘explain the basics’</td>
</tr>
<tr>
<td></td>
<td>‘give an idea of how to promote change, make changes and be change agents’</td>
</tr>
<tr>
<td></td>
<td>‘discover how to do more with less’</td>
</tr>
<tr>
<td></td>
<td>‘give realistic expectations and explain commitment required to manage a project’ (Dr)</td>
</tr>
<tr>
<td></td>
<td>‘to get results, but really this takes time and experience’</td>
</tr>
<tr>
<td>Redesign Leaders</td>
<td>‘to show that there is a methodology to follow, plus knowledge of AIM. That’s all you’d expect in 5 days’</td>
</tr>
<tr>
<td></td>
<td>‘just the basic concept of project management and implementation. I don’t expect them to have any diagnostic skills’</td>
</tr>
<tr>
<td></td>
<td>‘to implement small scale projects, not full redesign’</td>
</tr>
<tr>
<td></td>
<td>‘focus on Quality improvement in their own Department, with an emphasis on quick wins’</td>
</tr>
<tr>
<td></td>
<td>‘just scope and plan a project, they cannot be expected to ‘run’ a project’</td>
</tr>
<tr>
<td>Project Sponsors</td>
<td>‘to run and implement a project with limited assistance’</td>
</tr>
<tr>
<td></td>
<td>‘learn how to systematically address a problem using redesign methodology’</td>
</tr>
<tr>
<td></td>
<td>‘exposure to others, learn best practice and build networks to inform solution design’</td>
</tr>
<tr>
<td></td>
<td>‘skills development- engagement of staff, management and leadership skills’</td>
</tr>
<tr>
<td></td>
<td>‘access to some templates, tools and support to get the project going’</td>
</tr>
<tr>
<td>Program Facilitators</td>
<td>To build capability to support implementation of Models of Care</td>
</tr>
<tr>
<td></td>
<td>Apply project management skills to scope a project aligned to NEST</td>
</tr>
<tr>
<td></td>
<td>Build confidence in methodology</td>
</tr>
<tr>
<td></td>
<td>Build networks, provide support and encourage shared learning</td>
</tr>
<tr>
<td></td>
<td>Raise awareness of redesign methodology and resources available to support implementation</td>
</tr>
</tbody>
</table>

Figure 20: Language used by different stakeholder groups to describe the aim of the Program

While all stakeholders viewed capability development as a key outcome, LHD/SHN sponsors held higher expectations regarding outcomes and thought participants would be able to complete a project with minimal assistance.

There is a risk that the Surgery Redesign Training Program is not sufficiently differentiated from the Centre for Healthcare Redesign Diploma Program, as evidenced by the colloquial use of ‘short school’ and ‘big school’ respectively. According to Redesign Leaders and some project sponsors, the difference between the two Programs is not well understood by local managers. This is reflected in the high expectations of managers, who believe the five day
Program will deliver equal if not faster project outcomes of similar scope, with fewer resources required than a project undertaken through the Diploma Program.

5. **Findings (2): Key Factors for Success, Barriers and Challenges**

5.1 **Achieving Enhanced Workforce Capability**

The five day face to face training aspect of the Program is a knowledge building experience for participants, and is a considerable proportion of the value of the Program.

The evaluation process has established that the Program is successful in improving the knowledge and attitude of participants in relation to clinical redesign and project management. This establishes people who have attended the Program as resources who have foundational skills to contribute to clinical redesign projects of various scales in the future. The following are key success factors for the Program to achieve enhanced workforce capability:

- Teaching a methodology. Participants found a step-by-step process a useful tool for tackling challenging issues. Clinical redesign methodology and AIM are currently used, however there are other quality improvement methodologies which may be more suitable given the context and rapid teaching style of the Program e.g. 5S, Lean, clinical practice improvement etc.
- High quality expert presenters drawn from the health field who are willing to give ongoing advice to participants
- Mixed discipline group learning environment with networking encouraged (e.g. group work tasks, interactive discussion, sharing names and contact numbers of participants by ACI)
- Information booklet and USB resources. Many participants reported that they still referred to these resources regularly in the workplace
- Completing GEM e-learning modules to both prepare for the Program and to consolidate learning on return to the workplace
- Pleasant venue, catering and accommodation to support a positive reaction to the training experience.

Barriers and challenges to achieving enhanced workforce capability that were raised during the evaluation process are:

- Participant interest and willingness to attend and learn
- The intensive five day structure.

5.2 **Key Success Factors and Barriers to Achieving Project Outcomes**

The project management component builds on the foundational knowledge provided by the Program, to result in skill application and project outcomes. The evaluation process found that to increase the probability of a successfully implemented project, the following key factors should be present:

- Project assessed as viable, realistic, and sustainable
- Project has clear alignment with facility and District strategic objectives
- Project to have agreed and clearly defined deliverables with timeframes
- Project to have full support of senior management and clinicians
+ Redesign Leader involvement pre and post Program
+ Mixed discipline team attendance at five day training (e.g. an administrator and a clinician)
+ Allocated time during work hours for participant to progress project
+ Strong sponsorship at a facility or District Executive level, including medical sponsorship
+ Regular reporting and accountability to a local executive committee.

Challenges and barriers to successful implementation of project outcomes raised throughout the evaluation process are:
- Insufficient preparation of participants, particularly the explanation of the commitment and expectations of the participant and their project
- Unrealistic project scope
- Insufficient human resources dedicated to project
- Staff leaving and changing positions resulting in project failure
- Ineffective sponsorship
- Absence of reward and/or formal recognition as incentive

6. Discussion

The Program successfully achieves Kirkpatrick’s levels one through three from a participant perspective, with some discrepancy around the effectiveness of learning and application of behaviours from the perspective of Redesign Leaders and project sponsors. This likely stems from the expectations and experience differences of the respondents. Participants and Redesign Leaders acknowledged that skills consolidation is dependent on applying the methodologies to deliver a project, thus achieving level three outcomes is closely aligned to level four results. While there are opportunities to further enhance the learning experience, overall the Program imparts foundational knowledge and positively shapes the attitudes of participants. Although many rural and some metropolitan based participants felt that the Program structure and travel was tiring, all participants agreed that the benefits of the cross service networking and the group learning environment outweighed the negative aspects of the five day structure and metropolitan location.

The evaluation found that the coaching role of Redesign Leaders is pivotal to translating the knowledge gained from attending the Program into behavioural change and organisational results. However even with Redesign Leader input, the link between attending the Program and successfully implementing a project is tenuous as many participants are not adequately prepared or resourced to do so. The low number of successfully implemented projects supports this finding. The opportunity to successfully implement a project requires; ongoing Redesign Leader coaching, allocated time during work hours to progress the project, engagement of a strong local leadership body, effective sponsorship and accountability to local governance structures. Undertaking service redesign is challenging and time consuming; the project scope and timeframes must be realistically aligned to the level of experience of the project lead. This preserves the value of the methodology and ensures the ACI continues to be an effective partner in implementation.

Despite the limitations of the Program and the variety of alternative training programs available (e.g. Clinical Practice Improvement), there is strong support for continuation of the Program from LHD/SHNs. 86% of project sponsors interviewed stated they felt the Program
was needed and were keen to send more staff. Similarly, 88% of Redesign Leaders would recommend the Program to LHD staff, while 94% of participants agreed that the Program made a worthwhile contribution to their professional development. Consensus on the appeal of the Program focused on its short time commitment, rapid learning pace and the benefits of interdisciplinary state-wide networking. Executive project sponsors and participants agreed that the Program was uniquely accessible to medical clinicians for these reasons, evidenced by the increasing number of surgeons attending the Program.

The Program model is highly transferable to other areas requiring clinical redesign capability development. The core features of partnership with the Redesign Leader Network, the use of high quality presenters with expertise in the relevant area and cross-discipline team attendance must be present for this model to function successfully. The success factors for achieving enhanced workforce capability and project outcomes are applicable to many speciality subject areas using this model.

Recommendations for improving the Program were offered by stakeholders throughout the evaluation and collected by the evaluator. These recommendations were taken to a small solutions workshop which had representative membership from across the stakeholder groups on December 5th, 2013. Additional recommendations were made at the workshop. These recommendations focused on five main areas:

1. Improvements in the structure, content and delivery of the Program to optimise the learning experience
2. Defining the governance, accountability and reporting structures at ACI and LHD/SHNs
3. Robust process of participant and project selection and preparation prior to attending the Program
4. Proactive promotion of the Program in LHD/SHNs
5. Continuous improvement of the Program to align with the needs of LHD/SHNs through regular evaluation of participant experience, skills and project outcomes.

7. Recommendations

7.1 Refine structure, content and delivery

7.1.1 Structure
Shifting the Program from the December /January theatre down period will increase the likelihood of participants consolidating their skills on returning to work and will contribute to improved project momentum.

Extending the notification period for the Program from the current six weeks to three months will encourage adequate preparation and allow for local data collection to demonstrate a case for change. Extension of the overall structure of the program to include pre-program preparation of the participant and project will create time for preparatory discussions with the local Redesign Leader and project sponsor regarding scope, timeframes, resources and expected project outcomes. The nature and degree of preparation should be agreed between Redesign Leaders and Program facilitators.

The five day structure of the Program should be reviewed in light of participant feedback regarding the overly intensive nature of the Program. Splitting the experience into segments with weeks or months break would be less exhausting for participants but would also
considerably increase costs to LHD/SHNs. Attendance at each segment of the Program may be challenging and this more protracted commitment would likely decrease the attractiveness of the Program for medical clinicians. The costs and benefits of changing the five day approach need to be assessed in partnership with LHD/SHNs.

ACI could support LHD/SHNs and participants to maintain project momentum, consolidate skills, continue shared learning and successfully implement projects after completion of the Program by facilitating a group reporting structure for participants. Tools such as videoconferencing, Yammer, WebEx and webinars should be explored as options for giving progress reports at significant milestones by project teams to the group, thereby continuing the benefits of the group learning environment while minimising costs for LHD/SHNs.

ACI should investigate methods of formal recognition of the Program to incentivise participants to achieve project milestones and enhance the Program’s credibility. Options such as accrediting the Program through the Australian Health Practitioner Regulation Agency or the College of Surgeons which would allow participants to accrue Clinical Practice Development points should be explored. Incorporating a certificate in project management or healthcare improvement through an accreditation agency would acknowledge the work participants do and encourage managers and project sponsors to devote resources to achieving project outcomes.

7.1.2 Content

The value, timing and format of AIM training as part of the Program require review. Questions such as is all AIM content of use to the participant at this time and what elements of AIM do they need to know at this early stage of their Redesign experience should be explored. The benefits of focusing more on the clinical redesign methodology and providing an abbreviated version of AIM is an option to be considered by the Program facilitators.

As AIM training in its current two day format is now widely available throughout many LHDs/SHNs, the value of incorporating AIM into the five day face to face part of the Program structure should be reassessed. Attending AIM training before or after attending the Program are viable options and would incur minimal travel costs to LHD/SHNs, however staff would need to be released for extra days to attending, and training may not align with the timeframes of projects.

Program facilitators have identified benefits in teaching AIM during the last two days of the course as it takes advantage of the pre-existing group relationships and allows participants to apply the methodology to their project in the classroom setting. However the two days spent on AIM may be better utilised to further explore areas participant’s felt least confident in after completing the Program- data sourcing and analysis, diagnostic tools, designing solutions to a problem and writing skills.

Participants should be supported to produce quality written documents by increasing the focus on writing skills and through the provision of report templates for diagnostic, solution design and evaluation reports. The content of the Program should be reviewed by Program facilitators to address these areas.
7.1.3 Delivery

Improvements in GEM e-learning functionality should drive more use, with participants strongly recommended to complete particular modules before and after attending the Program to support skills consolidation.

Shared learning in a community of practice and strong links with the Redesign Leader network can be further emphasised by increasing the use of Redesign Leaders as presenters at the Program, and having past participants with successfully implemented projects present at future Programs.

7.2 Define governance, accountability and reporting structures

7.2.1 Governance and accountability within the lead agency

To effectively develop, deliver and support the Program, internal governance structures and resource requirements should be formally clarified and documented between the current lead groups including

- ACI Surgery, Anaesthetics & Critical Care Portfolio
- ACI Centre for Healthcare Redesign
- System Relationships & Frameworks Branch of the Ministry of Health
- Surgical Services Taskforce

There should be a review and update of documentation of the aims and objectives of the Program, taking into account the variation in expectations of stakeholders. This will provide clear accountabilities and identify resource requirements and allocations to deliver the Program. In addition, the relationship between the Program and the Surgical Services Taskforce should be strengthened, with the Taskforce becoming increasingly engaged in Program attendance, marketing, strategic direction setting and exceptional projects with potential for transferability.

7.2.2 Governance and accountability within LHD/SHNs

To facilitate successful delivery of project outcomes LHD/SHNs need to implement effective governance for projects, which includes

- embedding project reporting into local executive structures
- ensuring sponsorship is actively supporting each project, and includes a form of senior medical sponsorship or clinical leadership. The ACI has increased engagement with sponsors in the CHR Diploma Program. ACI should tailor this approach to optimise sponsorship of Surgery Redesign projects.
- early consultation and involvement of the Redesign Leaders in project and participant selection is recommended as this is shown to promote project completion. Redesign Leaders have expert knowledge on the skills and aptitude which supports successful redesign projects, as well as which issues are best approached using redesign methodology.

A checklist of recommended actions to support successful project delivery should be provided to participant’s LHD/SHN and at a facility level.
7.3 Improve project and participant selection and preparation

7.3.1 Project

Issues which are taken to the Program as projects should align with the redesign approach. The Redesign Leader is well placed to advise on this. Projects should reflect local surgery strategic priorities and be scoped to align with resource allocation and timeframes.

ACI should give at least three months of lead time to the Program to allow LHD/SHNs to select a project, allocate resources, identify a project lead and establish project governance structures.

7.3.2 Participant

Participants should have some level of authority and influence in their workplace, an interest in change and an aptitude for service improvement. A robust preparation process undertaken prior to the participant attending the Program will maximise the benefits of the training and increase the likelihood of the transfer of skills and project success. All participants would benefit from meeting with the Redesign Leader, project sponsor and local previous participants prior to attending the Program to discuss expectations, resources, deliverables and timeframes, underpinned by the completion of specific GEM e-learning modules. This is likely to considerably improve participant’s ability to maximise their knowledge and skills acquisition during the Program. Actions to encourage the attendance of medical staff such as greater engagement with the Surgical Services Taskforce or accreditation of the Program with the Royal Australasian College of Surgeons would increase the engagement of senior clinicians in the clinical redesign process. ACI should encourage the attendance of multidisciplinary teams of two or more people per project at the Program.

7.4 Active Program promotion

ACI should clearly articulate the Program structure to LHD/SHN executives and senior clinicians as a standalone professional development training experience, which can assist participants to deliver operational objectives if additional resources are provided to the participant. This approach is summarised in Figure 21 and will proactively manage the variation in expectations of participants and projects held by local managers and sponsors. The benefits and return on investment from Program attendance should be clearly communicated to LHD/SHNs to raise the profile of the Program and encourage organisations to allocate time, resources and recognition to the Program. This can be achieved by a ‘one-pager’ outlining the benefits and requirements of the Program as well as site visits by Program facilitators and Program sponsors to talk with senior managers about viable projects and to set expectations. ACI should be clear about what LHD/SHNs need to provide and what they can expect in return, reflected in the EOI letter sent to CEs about the Program and the application process.

ACI should explore options for differentiating the Surgery Redesign Training Program and the Clinical Redesign Diploma Program in the system. The inputs and possible outputs for each training experience are substantially different and it is vital that this difference be made clear to protect the value of the Diploma Program and to set the expectations of managers and project sponsors.
7.5 Introduce further evaluation measures to continue quality improvement

For the Program to continue to evolve while successfully meeting the changing needs of LHD/SHNs and surgical services in NSW regular evaluation from a participant, Redesign Leader, sponsor and facilitator perspective is required. In addition to participant evaluations completed at the end of each Program, a pre and post course self-completed skills assessment for participants will more accurately assess Level 2 learning. The Program facilitators should design a simple participant evaluation and skills assessment to incorporate into the Program. Redesign Leaders should assist in undertaking an evaluation of support, progress and sponsorship biannually, as well as collecting data on project outcomes. A full Program evaluation to validate investment every three years will ensure the Program continues to meet the needs of the LHD/SHNs and the people of NSW.

8. References


9. Appendices

9.1 Timetable for May 2013 Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday – 27 May</th>
<th>Tuesday – 28 May</th>
<th>Wednesday – 29 May</th>
<th>Thursday – 30 May</th>
<th>Friday - 31 May</th>
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<tbody>
<tr>
<td>1330-1630</td>
<td>1330 – 1630 Diagnostics Tools Matt Long</td>
<td>1330 – 1630 Project Planning, including scheduling Judy Willis &amp; Gavin Meredith</td>
<td>1545 – 1630</td>
<td>1545 – 1630</td>
<td>1545 – 1630</td>
</tr>
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## 9.2 Data Collection and Analysis

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Stakeholder group</th>
<th>Number Interviewed</th>
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<tr>
<td>Central Coast LHD</td>
<td>Participants</td>
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</tr>
<tr>
<td>Northern Sydney LHD</td>
<td>Participants</td>
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</tr>
<tr>
<td></td>
<td>Project sponsors</td>
<td>1</td>
</tr>
<tr>
<td>Sydney LHD</td>
<td>Participants</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Project sponsors</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Redesign Leaders</td>
<td>1</td>
</tr>
<tr>
<td>Murrumbidgee LHD</td>
<td>Participants</td>
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</tr>
<tr>
<td></td>
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</tr>
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<td>Illawarra Shoalhaven LHD</td>
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</tr>
<tr>
<td></td>
<td>Redesign Leaders</td>
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</tr>
<tr>
<td>South Eastern Sydney LHD</td>
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</tr>
<tr>
<td></td>
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<td>Nepean Blue Mountains LHD</td>
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<tr>
<td>Hunter New England LHD</td>
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</tr>
<tr>
<td>Western NSW LHD</td>
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<tr>
<td></td>
<td>Redesign Leaders</td>
<td>2</td>
</tr>
<tr>
<td>Southern NSW LHD</td>
<td>Participants</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Redesign Leaders</td>
<td>1</td>
</tr>
<tr>
<td>South Western Sydney LHD</td>
<td>Participants</td>
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</tr>
<tr>
<td></td>
<td>Redesign Leaders</td>
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</tr>
<tr>
<td>Western Sydney LHD</td>
<td>Participants</td>
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</tr>
<tr>
<td></td>
<td>Project sponsors</td>
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</tr>
<tr>
<td></td>
<td>Redesign Leaders</td>
<td>1</td>
</tr>
<tr>
<td>Sydney Children’s Hospital Network</td>
<td>Project sponsors</td>
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</tr>
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<td>ACI/Ministry of Health</td>
<td>Program facilitators</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Program Sponsors</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>37</strong></td>
</tr>
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</table>
9.3 Online Survey Formats

9.3.1 Participant survey format

This survey asks a series of questions that will be used along with more in-depth interviews with participants, project sponsors and Redesign Leaders, to help inform ongoing improvements to the Program.

Please work through the survey by reading each question and selecting the most appropriate response option from those listed, or where relevant, providing written feedback.

The survey should take no more than 15 minutes to complete. All responses are strictly confidential.

Please complete the survey by Friday 8th November 2013.

Thank you for your input.

*1. When did you attend the Surgery Redesign Training Program?*

- November 2011
- May 2012
- December 2012
- May 2013

*2. Did you attend the Program with a specific project?*

- Yes
- No

*3. What was your project topic?*

[Blank field for text input]

*4. Did you attend the Program as part of a project team?*

- Yes
- No

*5. Please select the disciplines that were part of your project team, including yourself.*

- Nurse
- Nurse Unit Manager
- Surgeon
- Anesthetist
- Resident/Registrar
- Administrative
- Allied Health
- Manager
- Other (please specify)

*6. What has been your overall level of satisfaction with the Surgery Redesign Training Program?*

[Rating scale with options: Strongly disagree, disagree, Neither agree nor disagree, Agree, Strongly agree]

- Overall, I was very satisfied with the program.
- The Program made a worthwhile contribution to my professional development.
- I would recommend the Program to others.
- I developed important new skills from the Program.
- The Program has equipped me to implement projects to improve healthcare delivery.

*7. What were the two main benefits you gained from the Program?*
8. How helpful was the Program structure, content and delivery?

The overall structure of the Program worked well for me
I found the Program content valuable for equipping me with the knowledge and skills to implement change in my organization
I found the Program a valuable networking opportunity
I have been in contact with one or more people I met through the Program to discuss a project or issue
I gained valuable skills in change management
I gained valuable skills in systems management
Please add any further comments on the structure, content and delivery of the Program

9. In light of your experience at the Surgery Redesign Training Program, please rate your current skill level in

Managing a change process in the workplace
Engaging and managing a project sponsor
Planning a project scope and timeline
Communicating with project stakeholders
Diagnosing the root cause of a problem
Data gathering and analysis
Designing solutions to a problem

10. Since completing the course, what has been your subsequent use of the skills and knowledge you acquired?

I have often used the skills and knowledge I acquired
I have been able to transfer these skills to others in my workplace
I have changed the way I think about change processes
I have changed the way I think about critical redesign
I have had a redesign or change management project on process
I do not feel confident to lead a redesign or change management process
Participating in the Program has helped me to gain a perspective or move into a new area of work

11. Please rate the extent to which the following statements apply

Not at all
Somewhat
Not sure
Moderate
To a large extent

I was able to work on my project during work hours
I had an effective sponsor for my project
There was good support from others in my workplace
My project relates to a local health service priority

12. What best describes the current status of your original project?

The project has not progressed at all
A project management plan was written but not endorsed
A project management plan was written and endorsed
A diagnostic process has been completed
A diagnostic and solution design process have been completed
The project has been partially implemented
The project has been fully implemented
The project has been fully implemented and evaluated
Other (please specify)
13. Did you attend any follow-up teleconferences with the Program Facilitators?
- Yes
- No

14. Were these teleconferences beneficial?
- Yes
- No

Please describe why these teleconferences were or were not beneficial.

15. Why didn’t you attend the follow up teleconferences?
- I didn’t want to
- I wanted to, but I was not given the time to attend by my manager
- I was getting support/advise on my project from other sources, so didn’t feel the need
- I wasn’t aware that follow up teleconferences were being held
- Other (please specify)

16. Do you think the Surgery Redesign Training Program could do more to help participants and organisations to achieve successful project outcomes?

17. Are there any aspects of clinical redesign or change management which were not covered in the Surgery Redesign Training Program which would have been useful to you or your project?
9.3.2 Redesign Leader survey format

This survey asks a series of questions that will be used, along with some in-depth interviews with participants, project sponsors and redesign leads, to help inform ongoing improvements to the Surgery Redesign Program.

The graph above shows the number of people in each District of Specialty Health Network that have attended the Surgery Redesign Program.

Please work through the survey by reading each question and selecting the most appropriate survey response from those listed, or where relevant, providing written feedback.

The survey should take no more than 15 minutes to complete. All responses are strictly confidential.

Please complete the survey by Friday 8th November, 2013.

Thank you for your input.

1. Are you involved in the selection or nomination process for the Surgery Redesign Program in your District?
   - Yes
   - No

2. Please describe your role in the selection process

3. Do you know who, from your District, has attended the Surgery Redesign Program?
   - Yes
   - No

4. Have you ever coached a participant of the Surgery Redesign Program while they worked on their project?
   - Yes
   - No

5. Would you recommend past participants of the Surgery Redesign School to act as a resource for future projects or change management processes?
   - Yes
   - No
   - I'm not sure
**6. Please rate the extent to which the following statements apply:**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Usually</th>
<th>Never</th>
<th>Mostly</th>
<th>Sometimes</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects that have been developed through the Surgery Redesign Program have been implemented</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The Redesign Leader(s) have an effective structure for connecting with Surgery Redesign Program participants to promote project progress</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Program participants have shared (Redesign Lessons) for help or input into a project</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My (name) and/or my unit(s) can benefit from the Surgery Redesign Program in terms of local change management support or organizational redesign processes</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Impact sponsors understand and embrace their role</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Program participants are given the time and resources needed to successfully implement their project</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**7. What are your expectations of the impact of the Surgery Redesign Program? (you may select more than one option).** After attending the Program, participants will...

- ☐ have the capacity to fully implement a clinical redesign project independently
- ☐ have the capacity to fully implement a clinical redesign project with the assistance of a Redesign Leader
- ☐ have the ability to facilitate a change management project and act as a change leader
- ☐ have knowledge and skills in change management, communication, project planning and stakeholder engagement, and will be able to apply these skills to their work environment
- ☐ be more open to engaging in change management processes in the future
- ☐ be aware of clinical redesign methodologies
- ☐ have access to resources currently available to support the successful implementation of projects
- ☐ Other (please specify)

**8. Would you recommend the Surgery Redesign Program to any of the following LHD staff? (you may select more than one option).**

- ☐ Surgeons/Anaesthetists
- ☐ Residents/Registrars
- ☐ Nurse Managers
- ☐ Nurses working on the floor
- ☐ Administrative staff
- ☐ Health Service Managers
- ☐ Health Service Executives
- ☐ No one
- ☐ Other (please specify)
9.4 Semi-structured Interview Format

9.4.1 Participant interview
1. Could you please tell me when you attended the course and the topic of your project?
2. What do you think was the main aim of the course? Do you think you think this was achieved?
3. Did you complete an application form?
4. Do you think you were the right person to attend this course from your organisation?
5. What were the three most important skills you gained from the course?
6. Have you been able to transfer these skills to others? Explore.
7. Have you used them in other contexts? Explore.
8. Were there any unexpected benefits or challenges from doing the course and the project?
   (Explore- tangible and intangible)
9. What did you most like about the course?
10. What do you see as the three main strengths of the Surgery Redesign Program?
11. What do you see as the three main weaknesses?
12. What do you think could be done to improve the course?
13. Did you access any GEM e-learning modules to build your knowledge?
14. Who chose this project and why? Do you think it was the right choice? Why?
15. How fully has the project been implemented? Has there been an evaluation?
16. How well has the project been sustained? Has it changed much over time?
17. What were the main challenges you experienced with your project? Behavioural, cultural, logistic, timeframes, resourcing...
18. How well do you think the Surgery Redesign School prepared you for leading the project and managing these types of challenges?
19. Did you connect with your District/Network’s Redesign Leader?
20. What sort of support did you receive from the... (Explore effectiveness of support).
   20.1. Redesign Leader
   20.2. Your sponsor
   20.3. Other management, your colleagues, staff from the Program.
21. How could your project have been more successful?

9.4.2 Redesign Leader interview
1. Could you please tell me a little about your involvement with the Surgery Redesign Program?
2. What are your expectations of the Program/what are the aims?
3. In your District or Network, how are Surgery Redesign Program participants chosen? Are participants enthusiastic? What would you recommend for the future?
4. In your opinion, what are the expectations of managers who nominate their staff to attend the Surgery Redesign Program?
5. Are you familiar with the content of the Program? Do you know what the participants learn about?
6. Do you think the format and delivery of the Program is conducive to developing change management and project management skills in the participants?
7. Would you like to see any changes made? E.g. explore resourcing, greater acknowledgement of role by LHD, more involvement with the Program- structure, frequency, participant selection etc.
8. What sort of skills do participants of the Program apply when then return to their LHD and start work on their project?
9. What have you found as the most effective way/s to mentor and support Surgery Redesign Program participants? Can you give some examples of where things you have done have been really effective?
10. How would you describe the support you receive from
   10.1. the Surgery Redesign Program
   10.2. your LHD management?
11. What do you think are the most critical things for an effective project lead and project sponsor in the context of the Short School?
12. Are you aware of any unexpected consequences of the Surgery Redesign Program participants and projects? (e.g. beneficial flow on effect to other staff, more doctors/ mixed discipline teams able to attend etc.)
13. How many of the Surgery Redesign Projects you have been involved in would you describe as ‘successful’?
14. With the Surgery Redesign Program projects you have been involved in, how many have been successfully implemented?
   14.1. What do you think have been the critical success factors?
15. How well have Surgery Redesign Projects been sustained?
16. Have you been involved in evaluation for any of the projects?
17. Attendance patterns of individual LHD
18. Main strengths and weaknesses of the Program?
19. If you were going to make changes to the Surgery Redesign Program so that it is more effective, what would you recommend?
20. Do you think that the surgical setting warrants its own Redesign Program? Do you think the 5 day Program would be beneficial for other clinical settings?
21. What benefits does a five day Redesign Program have over a 20 week Program?

9.4.3 Project sponsor interview

1. Could you please tell me a bit about your involvement with XXX (name/project) and the Surgery Redesign School Project?
2. What do you think were the main aims of the Program attended by XXX (name)? Do you think they achieved these?
3. Did you have any input into nominating this person to attend the Program?
4. Do you think XXX was the right person to lead this project in terms of their role in the organisation?
5. What factors do you consider/would you consider to be important when selecting/nominating/endorsing a participant to attend the Surgery Redesign Program? What qualities are essential? Time, drive, accountability/responsibility etc.
6. Who chose the project? Why? In retrospect, do you think this was the right project to choose?
7. What were the main challenges experienced with the project? Behavioural, cultural, logistic, timeframes, resourcing...?
8. Is the current progress of the project meeting your expectations? Timeliness, scope, momentum etc.
9. If implemented, how well has the project been sustained? Has it changed much over time?
10. What do you think were the critical success factors and main challenges/barriers?
11. Have you seen evidence of the use of a Redesign methodology?
12. Did you perceive any enhanced change management/planning/communication skills in the participant?
13. Aside from the project, do you see any other benefits of the Program?
14. What did you see as your main role as the sponsor for these Surgery Redesign Project(s)? Was this communicated clearly to you by your Project Lead? How was this conveyed?
15. Did you receive any information or support from the Surgery Redesign Program? Would this have been beneficial? If so, what type of support would you have most appreciated?

Are there any further comments you would like to make?

9.5 Redesign Methodology