

# CAPACITY BUILDING & CHANGE MANAGEMENT

A guide for community services



## ACKNOWLEDGEMENTS

This manual has been produced by the Victorian Alcohol and Drug Association (VAADA). The new manual is completely updated and extensively revised incorporating significant new material to ensure relevance to the broad community sector. It builds on 'Capacity Building and Change Management: A guide for services implementing dual diagnosis processes', a manual originally developed by Positive Directions, Consultancy and Training under the auspices of VAADA in 2012.

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## FOREWORD

There have been significant challenges in recent years in the not-for-profit sector. In particular, change is a constant along with increasing recognition of the ongoing need to examine and develop the capacity of our people and organisations.

In this new manual VAADA has sought to provide the field with a resource which can be used widely across the not-for-profit sector and particularly in agencies delivering primary health and community care services.

Not least of the current challenges faced by many agencies are funding constraints and increasing service demands. Consumers often present with a range of complex and co-existing issues. More and more both consumers and funders look to agencies to provide a holistic response to these issues.

In addition increasingly they look to agencies to involve consumers, their families and carers in determining how their problems would best be managed. Strong partnerships between agencies to enhance capacity, enable best practice and deliver holistic responses to consumer needs are critical.

This manual aims to equip agencies to meet these challenges. It offers useful strategies which are practical to implement. It also provides step by step guidance and templates to assist agencies to translate them into practice.

It builds on earlier work and particularly the 2012 VAADA manual *Capacity Building and Change Management: A guide for services implementing dual diagnosis processes* written by Positive Directions, Consultancy and Training. The earlier resource aimed to enhance organisational capacity for the alcohol and other drug (AOD) sector, more specifically in mental health.

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# CHAPTER 1 - ABOUT THIS MANUAL

## INTRODUCTION

### *The only constant is change*

Heraclitus (535–475BC)

Change is a concept which can conjure up lots of very different and conflicting emotions within us. Anxiety, a sense of achievement, excitement and fear are just a few. In fact the only thing about change which stays the same is that it is constant.

So why do we need to continually think about change and how we do it? As service providers almost all of us aim to make a positive difference in the lives of our consumers. Governments, community agencies and staff grapple with how to ensure that services respond to the changing needs of the people we exist to serve. In other words, we want to continually get better at what we do, increase our capacity and streamline our work so that it is as cost effective as it can be.

Change can be initiated by and/or from within a service organisation, or it can be brought about by shifts in policy and government priorities at the wider sector level. Differences in the level and type of changes required will also influence who needs to be involved. However, regardless of how change is initiated or how wide-ranging it is, organisations ultimately need to have already developed the capacity to respond to ensure the best possible outcomes for their consumers and the broader communities in which they operate.

This manual will equip you with the knowledge and tools you need to successfully implement change to develop the capacity of your organisation.

As you dip into it you will find it also directs you to many other resources available on change management and capacity building. This manual does not attempt to replace or replicate them. The focus is on community organisations and many of the challenges that are common to working in this diverse service system.

## WHY THE NEED FOR CHANGE MANAGEMENT AND BUILDING CAPACITY?

Community services are working with increasing numbers of people who experience complex problems such as alcohol and other drug use, mental illness, homelessness, family/domestic violence and family breakdown. Often they experience one or

more of these problems at the same time. This also adds complexity to service development and delivery.

Traditionally the various service sectors have operated from a 'specialist' delivery model, designed to treat only one problem at a time. More recently, an increasing body of evidence has influenced a change in international, national and state policy directions which requires a more holistic approach that considers the often multiple needs of individuals and families who are seeking assistance from community service organisations.

## RESPONDING TO CONSUMERS WITH COMPLEX NEEDS

It is understood that people presenting with complex needs typically experience poorer outcomes across a number of key life domains. A high level of responsiveness across all service sectors and levels of care is required to ensure effective treatment and support. This requires an integrated approach to assessment, treatment planning and delivery, rehabilitation and recovery, and exit planning and aftercare support.

Some factors that highlight the need for change to increase agencies' capacity include:

- Increasing numbers of people with complex issues need and use services in different sectors. Emergence of co-occurring and complex problems and other difficulties are occurring at an increasingly younger age.
- Complexity is associated with poorer outcomes and increased risks to health and development over time if not treated early and effectively.
- Long-term benefits for individuals, their families and/or carers and communities can be achieved through the early recognition and timely treatment of serious health problems and co-occurring issues.
- Services in different sectors record significantly lower rates of co-occurring issues among those using their services than would be expected from census and population surveys. This raises a number of concerns about recognition and response to dual problems in services as well as about the adequacy of routine data collection to inform service planning.
- Despite examples of good practice, all services typically continue to provide segregated services for consumers, rather than integrated approaches to treatment and care.
- System barriers that impede integration of treatment, care and recovery (both centrally at a policy level and locally at a service level) need to be systematically addressed if outcomes for complex consumers are to be improved.

(Victorian Department of Human Services, 2009)

## POLICY AND PRACTICE CHANGE

Unsurprisingly, policy directions now promote an integrated approach to service delivery. This new approach creates dilemmas for traditional, single-treatment service agencies. It requires a philosophical change in the way the sector delivers its services.

However, the evidence is increasingly accepted that the capacity to effectively respond to the complexity and interrelated needs consumers present with delivers much better results. The delivery of effective services also relies on the provision of holistic interventions centred on the needs of the individual and their family or carers. This is discussed further in Chapter 7.

## NEW APPROACHES TO FUNDING

Shifts in policy and increasing focus on partnerships and collaboration, service integration, and enhancing and measuring outcomes for consumers, are all factors that drive change. In addition the community services sector is experiencing the impact of new funding and performance management models. Enhanced capacity may be critical to deal with new criteria for, and approaches to funding.

Competitive tendering processes, for example often result in the need for agencies to change the way they do business. This can be vital to maintaining their existing service delivery funding and although such economic principles may be at odds with notions of collaboration and partnerships, it is clear that commercial drivers will continue to be a feature of the community service environment in the future.

Sometimes these developments generate sweeping changes across the community sector. They can result in major changes to the structure of service systems and where agencies fit within them, and ultimately to the delivery of services to consumers. Services may be under considerable pressure to demonstrate enhanced capacity. Utilising the change management strategies outlined in this manual can really help to deliver that enhanced capacity.

## WHAT KIND OF CHANGE IS NEEDED?

How effectively an organisation can develop greater capacity, whether this is in order to align itself with a new policy direction, service system or funding requirements, is dependent upon its capacity to adapt and evolve. The need for change may affect all areas of an agency's business from its infrastructure, governance and programs, to relationships with government and funding bodies. This makes organisational adaptability underpinned by a good understanding of change management increasingly important.

Many agencies and organisations in the community sector have been working to build their capacity for many years. In line with the evidence they have also been working to deliver improved capacity within their own service(s) and to enhance their respective service system to be responsive to changing needs and demands. Service system development that delivers a 'no wrong door' approach requires particular attention to:

- Strong understanding of change management and how to deliver it
- Promotion of responsiveness in the attitudes and values of providers which is reflected in policy and procedures
- Development of the workforce (ensuring essential competencies for clinicians, professional development, supervision and mentoring)
- Valuing of consumer perspectives and the outcomes they seek
- Maintenance of robust partnerships with other services

The advice and practical tools in this manual address all these issues. They are intended to encourage both agencies who want to begin the journey as well as agencies already on the path to develop their own capacity and that of the service system more generally.

## WHO SHOULD READ THIS MANUAL?

The manual is written for all those in the community services sector who wish to move their agency towards greater capability to deliver programs to consumers in a more integrated, collaborative way. There are usually one or more key people in an organisation who drive the change process. If you are a champion or change agent within an organisation, then this manual is definitely for you!

However everyone involved in your organisation has a part in change management, and with developing its capacity to deliver the change. So from the beginning, it is important to involve everyone and ensure that they understand how they can contribute.

As we discuss further in subsequent chapters everyone with whom your service has contact can also play a role. You might want to share the information in this manual with some of them too.

# CHAPTER 2 - ABOUT CHANGE

## INTRODUCTION

The development of a service system’s capability is an evolutionary process, as with any major philosophical shift in service delivery. It necessarily involves change.

Change can involve everyone from consumers and volunteers to staff and board members. Therefore, a clear understanding of how people respond to change and how your organisation can support people through it and beyond is pivotal. As the organisation and its staff transition through the change everyone is likely to require support through the process.

## WHAT DOES CHANGE INVOLVE?

One of the most influential models of organisational change is the Kotter model from the Harvard School of Business. It comprises eight overlapping steps (updated in 2015). They are the basis of three core phases that inform this manual:

- Creating a climate for change
- Engaging and enabling your organisation
- Implementing and sustaining change

Having developed the original model, a critical point in thinking about how to implement change management and build capacity came with the subsequent realisation that any successful change strategy requires attention to changing people’s hearts as well as their minds (Kotter and Cohen 2012 *The Heart of Change*).

The way in which this influences the 8-step process is also captured in an amusing [youtube clip](#).

It recognises that change involves ‘outer’ shifts in processes, strategies, practices and systems. It also relies on ‘inner’ shifts in how people feel – their values, aspirations and behaviours.

Managing change is not just about enhancing an organisation’s technical capacity. If it were, we would be introducing and discussing quality improvement processes and little else. The change management this manual aims to promote involves embracing a particular philosophical view that delivering care in a more holistic, integrated way will better meet consumer needs.

Table 1: John Kotter’s 8-step change model comprises eight overlapping steps and the table below is adapted from Kotter’s work. The first three steps are about creating a climate for change. The next three are about engaging partners and stakeholders and enabling the organisation. The last group address implementing and sustaining change.

Action	New Behaviour
<b>Creating a climate for change</b>	
Develop a sense of urgency	As the case for change is developed, people from Board and management level down start telling each other, “Let’s go, we need to change things!”
Build a powerful guiding team	A coalition of stakeholders and partners powerful enough to guide a big change is formed and they start working together well.
Get the vision right	The guiding team develops the right vision, values and strategy for the change effort.
<b>Engaging and enabling the organisation</b>	
Enlist broad based ‘volunteer army’ communicating the vision to increase buy-in	As the guiding team communicate and coordinate their activities, people begin to buy into the change, and this shows in the growing army of ‘volunteers’ and their behaviour.
Empower action by removing barriers	More people feel able to act, and do act, on the vision as they are invited and encouraged to help your organisation implement its strategies.
Create and celebrate short-term wins	Momentum builds with early wins and as more people are motivated to try to fulfil the vision, fewer and fewer resist change.
<b>Implementing and sustaining Change</b>	
Don’t let up now!	People make wave after wave of changes sustaining the acceleration of change until the vision is fulfilled.
Institute changes and celebrate to make change stick	Changes are embedded and celebrated persistently so that new and winning behaviour continues despite the pull of tradition, turnover of change leaders etc.

Based on Kotter’s 8-Step Change Model for Successful Transformational Change. Source: Kotter and Cohen, (2012) *The Heart of Change: Real life Stories of How People Change Their Organisations* p 7.

## THE DIFFERENCE BETWEEN CHANGE AND TRANSITION

Society correctly associates change with transition. It is the transition that helps us move to and achieve a desired change. We can think of transition as involving a psychological shift that helps us move to that change. In this way:

**Change is situational** – for example, moving to a new city or shifting to a new job.

**Transition is psychological** – it is the inner reorientation and self-redefinition that you have to go through in order to incorporate changes in your life.

Without a transition, a change is just a rearrangement of the furniture. Unless transition happens, the change won't work because it doesn't 'take'. This process is described by William Bridges in detail in his 2009 book, 'Managing transitions: making the most of change'.

## TRANSITION 'ABLE' ORGANISATIONS

In a perfect world, transition 'able' organisations would have in place all of the policies, roles, culture, leadership, structure, resources and histories to provide a supportive environment for successful transitions. In the real world however, most organisations are somewhere along the continuum towards developing these. Even if you don't have everything in place or you don't have a history of supportive change in your organisation you can still make a start. This manual is intended to help ensure that organisations are able to become adept to transitioning in often dynamic environments.

Bridges suggests some strategies organisations can use to help people through the transition phases:

- Work less with the change management and more with the transition management
- Remember that change is perceived personally, yet we try to deal with it organisationally. The more included people are early in the development of an idea, the easier and quicker they can begin their transition
- Be mindful that each person transitions at their own pace
- Attempts to 'sell' the new beginning zone to staff will not move them towards leaving the ending zone
- Movement occurs when you show that you understand the individual's transition

Change is a slow process. At the same time creating some sense of urgency is important to getting 'buy in' to the need for change to occur at all. Timelines need to be realistic but also variable depending on the type of change articulated in each step of your change management plan. All people promoting and driving the

change process must be able to analyse the system or agency in which they operate and understand what is required to bring about change. It is important to be aware that changes in any part of a system will have an impact on every other part of the system.

## PREPARATION FOR CHANGE

As a change agent, it is imperative that you consider and understand the culture, values, people and behaviours at your workplace when articulating or suggesting a need for change. Holt et al, 2007 describe readiness for organisational change as being:

*'A comprehensive attitude that is influenced simultaneously by the **content** (i.e., what is being changed), the **process** (i.e., how the change is being implemented), the **context** (i.e., circumstances under which the change is occurring), and the **individuals** (i.e., characteristics of those being asked to change) involved.'*

It is especially helpful if you are able to consider previous responses to attempts to introduce change in your organisation.

- How has change happened in your workplace previously?
- What strategies to achieve change have been successful and not successful and why?
- Do you have to start from scratch again or can you build on previous change processes?
- How do staff normally respond to a new idea or process?
- Is change traditionally perceived as a threat or an exciting opportunity?
- How does management support and view change?
- How do you see change?

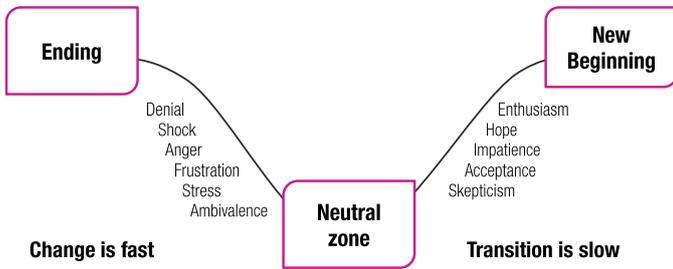
The important thing to remember is that training alone will not create staff that are capable and accepting of change in all its forms. A capable organisation has the commitment to ongoing learning, development and support of its staff. Also remember the importance of mentoring and supervision in this process.

## PHASES OF TRANSITION

Bridges describes three phases of transition people will experience during change:

1. The ending
2. The neutral zone
3. The new beginning.

Figure 1: Transition process

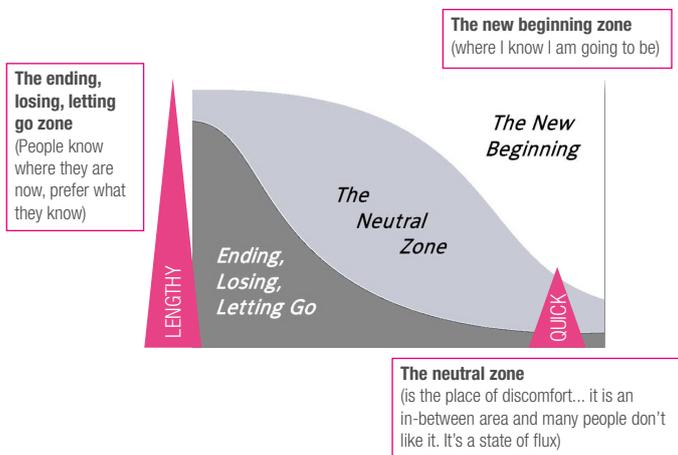


Source: Bridges (2009) – Reproduced with permission

## SUPPORTING PEOPLE THROUGH TRANSITION

Understanding the transition phases and how people respond to change is crucial to recognising the needs of staff and other stakeholders as they move through transition. As we have already noted and will discuss further, supervision and mentoring are key professional skills. They also provide useful strategies for supporting staff through periods of change.

Figure 2: Understanding the phases of transition



Source: Bridges (2009) – Reproduced with permission

Bridges also suggests ways that managers can assist staff and other stakeholders through transitions as described in Table 2. Some further strategies are discussed in the section titled 'Dealing with resistance'.

Table 2: Transition phases and managers' tasks

Transition phase	Description	Managers' tasks
Ending (losing, letting go)	Tangible and intangible losses can lead to emotions such as denial, shock, frustration and anger.	Support people to deal with their tangible and intangible losses and mentally prepare to move on.
The neutral zone	The person will find themselves in a 'neutral zone' for a period of time where they may feel some ambivalence or scepticism, but they are beginning to let go of the old and move on to the new. Critical psychological realignments and re-patterning takes place.	Support people to get through it and capitalise on all the confusion by encouraging them to be innovators.
The new beginning	This last phase of the transition will take the person through scepticism, acceptance, hope and enthusiasm until they embrace the 'new beginning'.	Support people to develop their new identity, experience new energy and discover the new sense of purpose that will enable the change to begin to work.

Adapted with permission from: Bridges (2009)

## RESISTANCE TO CHANGE

As you might conclude from Bridges' model, transitions and change can be a messy process and resistance to change often results. This is an unavoidable part of any change process that it may be considered a survival mechanism within organisations. There are a number of reasons why people resist change, so it is important to identify the root causes in order to plan some of your strategies for implementation.

When you understand what lies behind people's concerns, you can begin to reduce them, using a range of strategies. Using the tips for open communication discussed above and your champions and change agents will help. Use the Resistance Assessment Survey tool (available at Chapter 11 of this manual) to help you identify some of the sources of resistance in your organisation.

Resistance shouldn't be seen as a negative or undermining response that needs to be 'managed'. Often it reflects a genuine concern that, if recognised, can provide greater clarity and focus to the changes required. Open communication and willingness to address these concerns is essential.

Much of the literature on resistance to change quotes Rick Maurer (2009) and the three levels of resistance he describes in “Introduction to Change without Migraines”. These are:

- Level 1 – I don’t get it
- Level 2 – I don’t like it
- Level 3 – I don’t like you.

### ***Level 1 – I don’t get it***

Level 1 involves information: facts, figures and ideas. It is the world of thinking and rational action, presentations, diagrams and logical arguments.

Level 1 resistance may come from:

- lack of information
- disagreement over interpretation of the data
- lack of exposure to critical information
- confusion over what it all means.

Giving people information and evidence is important and is the most common way organisations try to deal with resistance. However beware of treating all resistance as if it were Level 1.

### ***Level 2 – I don’t like it***

Level 2 is an emotional reaction to change. People may be afraid that this change will affect how they do their job or the quality of the services they offer. They may also be afraid that change will cause them to lose face, status or control – maybe even their jobs.

When Level 2 is active, it makes communicating change very difficult. People stop listening.

### ***Level 3 – I don’t like you***

Level 3 is a major reason why resistance flourishes and changes fail. Maybe they do like you, but they don’t trust or have confidence in your leadership.

In Level 3 resistance, people are not resisting the idea. In fact, they may love the idea you are presenting. They are resisting you. Maybe their history with you makes them wary. Perhaps they are afraid that this will be ‘a flavour of the month’, like so many other changes, or that you won’t have the courage to make the hard decisions that will see this change through.

It may not be you. Perhaps people have had a bad experience with change and leaders before. Or they may be resistant to those that you represent. The moment that some people hear someone from management is present and wanting to help, they become sceptical. If you happen to be that person from management, you’re going to have a hard time getting those people to listen.

## DEALING WITH RESISTANCE

### IDENTIFYING RESISTANCE

It is important that you identify resistance early and reassess as you move through the change process. The three types of resistance can occur at any stage. Use the Resistance Assessment Survey in the Tools and Templates section of this manual to help you.

### MANAGING RESISTANCE

There are a number of ways that you can deal with this resistance, all of which involve open, honest and two-way communication.

#### **Level 1: Make your case**

- Make sure that people know why a change is needed. Before you talk about how you want to do things, explain why something must be done.
- Present the change using understandable language.
- Find multiple ways to make your case. People take in information in different ways. Some like to hear the data, while others prefer visual sources like pictures or text. Some people learn best by interacting in a group or through conversation. The more variety in the communication channels, the greater the chance that people will comprehend what you have to say.

#### **Level 2: Reduce fear and increase excitement**

- Remove as much fear as you can and increase staff excitement about what’s positive in the change.
- Emphasise what’s in it for them. Staff need to understand that these changes will benefit them as well as the consumers. For example, you could explain that work will be easier, relationships will improve, career opportunities will open up or job security will increase.
- Engage people in the process. People are far more likely to support things they have a hand in creating.
- Be honest. If a change will hurt them, tell them the truth. It’s the right thing to do and it stops the rumour mill from inventing stories about what might happen. Also, honesty bolsters their trust in you (a Level 3 issue).

#### **Level 3: Rebuild damaged or neglected relationships**

- Take responsibility for things that may have led to tense relations.
- Keep commitments. Demonstrate that you are trustworthy.
- Find ways to spend time together so they get to know you and your team. This is especially helpful if the resistance comes from people’s attitude towards those whom you represent and not just from your personal history together.

- Allow yourself to be influenced by the people who resist you. This doesn't mean that you give in to every demand, rather it demonstrates that you are not rigid, and that they may have ideas worth considering.

## SUPPORT MATERIALS

- » Bridges, W. (2009) Managing transitions: making the most of change, Lifelong Books, San Francisco.
- » Kotter, J. and Cohen, D. (2012) The Heart of Change: real life stories of how people change their organisations
- » Kotter, J. (2014) XLR8 Accelerate: Building Strategic Agility for a Faster-Moving World
- » Kotter's 8 Step amusing [youtube clip](#)

## HELPFUL TIPS

- » Change initiatives which consider engaging people's hearts as well as minds are more likely to succeed.
- » Remember that any change process involves periods of transition for everyone, and that your staff will need to be supported.
- » Think about how change might affect your organisation. Make sure you are clear about what kind of change you are planning and understand the impacts of that change on all parts of your organisation.
- » Resistance is a natural part of the change process that can occur at any stage.

## TOOLS

- » Templates and Tools No 1: Resistance Assessment Survey

# CHAPTER 3 - BUILDING CAPACITY & CAPABILITY

## INTRODUCTION

This Chapter explores the concepts of capacity and capability building and the relationship between them. It also explores what a capable organisation might look like and the role that policies and procedures play in delivering enhanced capacity.

### WHAT IS CAPACITY BUILDING?

Generally speaking, an organisation with 'capacity' is one which is able to meet the needs of the people it serves. An organisation that is already meeting these needs is also in a much better position to evolve and meet external challenges such as a sector wide reform.

Capacity building and the related concept of 'capability building' are applied in many fields.

However regardless of whether capacity building is desired in a corporate or community services environment, it inevitably involves a process of transition (or change). It involves more than improving technical skills, developing new systems or establishing quality assurance and improvement standards. These are important, but strengthening capacity is essentially about changing behaviour.

This is why thinking about capacity building as a process is useful. It takes focus, commitment and time and is likely to need careful management. As LaFond and Brown (2003) suggest, it is a process that aims to improve the ability of a person, group, organisation, or system to meet objectives or to perform better.

By means of partnerships, policy and leadership, capacity building enables new learning and awareness to be transferred into sustainable action. For these reasons the UN Development Programme stresses that capacity building is a process of enhancing not only human but also institutional capacity (European Portal for Action on Health).

### So why is strengthening capacity and capability so important?

In the health and community services sector they are particularly important concepts because they direct attention to equity. They are approaches that "increase the range of people, organisations, and communities who are able to address health problems and, in particular, problems that arise out of social inequity ..." (NSW Health 2001) They can help develop sustainable skills, structures, resources and commitment to health and other sectors to prolong and multiply health gains many times over (Hawe et al, 2000).

### Capacity and capability

In this manual the term 'capacity building' is predominantly utilised. However capacity and capability are concepts that work together and the terms are often used interchangeably.

**Capacity** – is about the question "Do we have enough?" and the related question, "How much is needed?" It is about having the right number and level of people able to take the required action.

**Capability** – is about the features, competencies or processes that can be developed or improved to deliver the capacity required. It is about having not just enough people but those with the confidence and knowledge to lead change. Capability is a collaborative process through which individual competencies can be applied and exploited. The relevant question for capability might be not "Who knows how?" but "How can we get done what we need to get done?" Vincent (2008).

Thinking beyond individuals, capacity building has been defined as 'an improvement in the ability of public sector organisations, either singly or in cooperation with other organisations, to perform appropriate tasks.' (Determine Consortium, 2009) Another definition refers to capacity building as 'an approach to development that ... gives people and organisations a greater ability to address new challenges, whatever those challenges may be'. (NSW Health, 2001)

The EU-funded "DETERMINE Consortium for action on the socioeconomic determinants of health" ([here](#)), identified five further priority areas necessary for developing organisational capacity to effectively address health and social inequalities. Beyond individual skills, they include:

- policy development
- organisational development
- building the evidence base and awareness raising.

Partnership development and leadership is also identified as a key way to enhance capacity. This aspect of capacity building is defined as the process of examining how different organisations within the health sector, as well as externally, can collaborate and promote leadership on health inequities.

### WHAT DOES A CAPABLE ORGANISATION LOOK LIKE?

A capable organisation is one which effectively combines its people skills with its structures, systems, cultures and processes to meet its desired service outcomes. However, it is also able to readily adapt to new directions across all of its programs. It does not treat adaptability as limited to a periodic need to respond to specific demands for change.

A capable organisation is one which consistently meets its objectives and goals. It achieves this by focusing on the internal processes and systems for meeting its consumer’s needs. It ensures that its workers have the necessary competencies and skills for quality service delivery.

A capable organisation is also responsive. It understands and manages organisational systems to meet the changing needs of the people who use its services. It also understands and manages the challenges of changes at the wider sector level. Critically, it achieves this by being constantly adaptable to new directions, often within relatively short time periods. In other words, it has a good grip on change management and how to achieve it.

Characteristics will include:

- A shared vision
- Leadership at all levels of the organisation
- Consistent and thorough management policies and procedures
- Internal infrastructure that supports the development of capacity and capability.
- Good quality educational programs for workers
- Quality supervision and mentoring

At a clinical level capable programs typically:

- Address the complex needs of consumers in their policies and procedures, assessment processes, treatment planning, program content and exit planning
- Have arrangements in place for coordination and collaboration between services
- Have staff able to address the interaction of multiple presenting issues and how these may be impacting the wellbeing of consumers and their ability to initiate changes in behaviour

Specific areas of capacity and capability may differ across the health and community sectors and within services. For example, the capability of a housing intake worker assisting a consumer to find stable accommodation will be different to the capability of staff in an alcohol and other drug (AOD) withdrawal unit responding to the needs of people who also experience mental health issues.

*The evolving concept of ..... capability refers to the notion that every agency/program providing behavioural health services must have a core capacity, defined through specific components of program infrastructure like policies, procedures, clinical practice instructions and standards, and clinician competencies and scopes of practice, to provide appropriate services to the individuals and families who are already coming through its doors. Minkoff and Cline (2006).*

**POLICIES AND PROCEDURES**

An organisation’s policies and procedures make a real difference to their capacity to deliver on their goals and objectives. This is because policies and procedures are the strategic link between an agency’s vision and its day-to-day operations.

It means that well written policies and procedures are one of the keys to building an organisation’s capacity. They allow employees to understand their roles and responsibilities within predefined limits and allow management to guide operations without constant intervention. They also provide a record of accountability for certain decisions made by staff, consumers, carers and management. They are important tools to promote responsiveness to the complexity of consumer, carer and broader community needs as well as to their goals in the attitudes and values of providers.

Not surprisingly most capacity building strategies and activities will have an impact on current policy and require the revision of your organisation’s policy and procedures.

***Difference between policy and procedure***

A ‘policy’ is a predetermined course of action established to provide a guide toward accepted agency strategies and objectives. Policies identify the key activities of the organisation and provide a general strategy for staff on how to handle issues as they arise.

A ‘procedure’, on the other hand, aims to provide the reader with a clear and easily understood plan of action for what is required to carry out or implement a policy. A well-written procedure will also help eliminate common misunderstandings by identifying job responsibilities and establishing boundaries for the employees in specific roles.

<b>Policy</b>	<b>Procedure</b>
<b>Is general in nature</b>	Identifies specific actions
<b>Identifies company rules</b>	Explains when to take actions
<b>Explains why they exist</b>	Describes alternatives
<b>Tells when the rule applies</b>	Shows emergency procedures
<b>Describes who it covers</b>	Includes warning and cautions
<b>Shows how the rule is enforced</b>	Gives examples
<b>Describes the consequences</b>	Shows how to complete forms
<b>Is normally described using simple sentences and paragraphs</b>	Is normally written using an outline format

Each core change embedded into an agency will need to be reflected in agency policy and procedures. These may be designed as either: a combined manual and/or complementary documents.

## SUPPORT MATERIALS

### Suggested reading:

- » Your current agency policy and procedure manual  
Network of Alcohol and Other Drug Agencies (2015), NADA  
Policy Toolkit, 2nd Edition (ONLINE): [Access it here](#)

## HELPFUL TIPS

- » Be mindful that capacity building is necessary if we are to evolve to better meet the needs of the populations to whom we deliver services.
- » Be aware that an organisation must already be capable if it is to be responsive to changes at the wider sector level.
- » Use a comprehensive approach which includes the development of a shared vision, good leadership and consistent management practices, infrastructure, and workforce development.
- » Understand the policy and process challenges you face. Consider which policy and procedures you may need to adapt and review as part of your implementation plan.
- » Aim to develop practical, clear tools that are relevant to your specific needs and context. You may find it helpful to use support materials to help you think about all areas of your activities.
- » Don't reinvent the wheel ... use policy examples and templates from other organisations or capacity building experts to guide your own.
- » Inform all staff of changes to policy and procedures and support them to implement the changes correctly.

## FURTHER SUPPORT MATERIALS

- » Hare, P., King, L., Noot, M., Jordens., Lloyd, B., (2000) *Indicators to Help with Capacity Building in Health Promotion*, Australian Centre for Health Promotion, NSW Health Department
- » NSW Health Department (2001) *A Framework for Building Capacity to Improve Health*
- » FHI 360 (2013) CAPACITY STRENGTHENING FRAMEWORK: A guide to facilitating collaborative, sustainable solutions  
[Access it here](#)
- » DETERMINE Consortium for action on the socioeconomic determinants of health (2009) Capacity Building and Awareness

Raising Actions to Address the Social Determinants of Health and to Improve Social Equity

- » Menu for CAPACITY BUILDING & AWARENESS RAISING ACTIONS undated [Access it here](#)
- » European Portal for Action on Health Inequalities  
[Access it here](#)

# CHAPTER 4 - BUILDING THE WORKFORCE

## INTRODUCTION

Developing the capacity of your workforce is clearly a pivotal component of building your organisation's capacity. Workforce development refers to activities which build the capacity of individuals to participate in an effective way in the workforce. It's also essential to developing their preparedness for and capacity to participate in change processes.

### THE CAPABLE WORKER

To meet capacity building outcomes of delivering services to meet consumer needs, agencies and organisations need to attract, recruit and retain a suitably skilled workforce. Workforce development therefore extends beyond just training, and involves human resource management and development activities. To maintain a highly skilled and competent workforce, these activities must also be ongoing and sustainable.

There has been a great deal of discussion and literature recently about what capability is and how we know what a capable worker is. Capability of staff can be divided into three levels:

- basic competence
- intermediate competence
- advanced competence.

At a basic level, the literature suggests that an ability to welcome and engage with the consumer is essential. All three levels can be measured through a range of other skills and knowledge that include:

<b><i>Ability to welcome and engage with the consumer</i></b>	
<b>Conceptual and theoretical issues</b>	Screening and assessment
<b>Risk assessment</b>	Knowledge of service systems and community sectors
<b>Relationship of presenting, and co-existing problems</b>	Symptoms, diagnoses and classifications of any disorders
<b>Treatment strategies</b>	
<b>Integrated treatment</b>	Partnerships b/w agencies and sectors
<b>Referral pathways</b>	Policy/Legislation
<b>Outcome measures</b>	Use of validated tools to measure what is being achieved for the consumer at the service level

### ***Essential areas of competence***

Recently Graham and White (2011) described the competencies that they believe are essential to assist consumers with complex needs. They described three overarching areas that must be addressed:

**Essential knowledge** – important information and knowledge that anyone working with complex needs consumers should possess. This includes a basic level of understanding and skills.

**Core practice skills** – those skills that most productively assist practitioners to effectively work with people with complex needs.

**Specialist skills and leadership** – attributes required for higher level work or management tasks in relation to improving services.

### HOW TO PRODUCE CAPABLE WORKERS

There are many paths to becoming capable and these should be guided through a well-articulated workforce development process. Planning to address this is a key part of your capability strategy.

As noted, workforce development is more than training. It includes a broad range of strategies targeted at systemic or structural issues, organisational functions and individual needs. These strategies include recruitment policies, remuneration, supportive management practices and policies, workplace learning opportunities and career pathways, training opportunities, supervision and mentoring, and staff exchanges. Local partnerships can also help foster these arrangements and open doors to staff exchanges and other joint strategies.

Even when there are few avenues to increase resources, workforce development can support improved service quality and staff retention by encouraging the professional development of staff. To achieve this, there needs to be a clear commitment by managers, governing bodies and staff.

Different pathways workers can take to become more capable may include:

- educational programs
- recognition of prior learning
- self-assessment checklists
- supervision and mentoring
- observation and assessment of specific skills
- a combination of any or all of these.

It is recommended that an audit of staff training needs be carried out across the organisation, using a capability assessment tool,

and that individual development programs be developed to address specific needs. An example of a training needs analysis (TNA) is found in Tools and Templates No: 2.

## SUPERVISION AND MENTORING

Supervision and mentoring are essential skill and role development strategies for many professionals and other staff in the health and community sectors. They are also useful strategies to employ when developing capable staff and supporting staff through a change process.

### SUPERVISION

Ultimately, supervision aims to promote improved services to consumers. It achieves this by encouraging reflective practice by practitioners. It gives staff the opportunity to stand apart from, discuss and reflect on their work. They can reflect on the context and the impact this has on the consumer and on themselves – as people and as professionals.

Supervision has been a core practice for many years in a variety of settings. The key components of supervision include:

- skills development
- education and training
- support
- theory development and practice integrations
- role development
- modelling
- quality assurance.

It is well documented that staff in clinical positions require regular supervision from experienced and trained supervisors. This ensures a shared understanding among all staff of the professional and organisational expectation for supervision, as well as the function, process and structure it will provide.

### *Types of supervision*

#### **1. Administrative/management supervision**

A manager who is responsible for the overall performance of a team or program provides this. Administrative matters relating to service planning, development and delivery are addressed by ensuring that program activities are carried out in a manner that is consistent with funding and legislative requirements, job descriptions, work plans, external policy directions and internal policies and procedures.

#### **2. Clinical supervision (individual or group)**

Clinical supervision can be provided within a group context or through a one-to-one relationship. The focus is on the delivery of clinical practice and the challenges and learnings that the clinician

experiences. Supervision is a formal process of consultation between two or more professionals. The focus is to provide support for the person(s) supervised in order to promote self-awareness, development and growth within the context of their professional environment (Hancox & Lynch, 2002).

Group supervision provides an opportunity for those supervised to experience mutual support, share common experiences and solve complex tasks. They can also learn new behaviours, participate in skills development and increase interpersonal competencies and insight. The essence of group supervision is the interaction of those supervised (MacKenzie, 1990).

Collegial supervision allows for a further development in the way supervision is provided. It can focus on a specific professional body, a specific skillset or specific training content. Collegial supervision is where colleagues work together and offer each other feedback on their practice. An example is a group of clinicians meeting to consolidate their newly acquired skills in motivational interviewing. Another example might be a project management group regularly meeting to discuss the implementation of their projects.

### ***Benefits of supervision***

When done well, supervision and mentoring reduces levels of staff burnout, increases job satisfaction and promotes quality practice. Coleman (2002) suggests that supportive supervision is concerned with increasing job performance by decreasing job-related stress. It increases the worker's motivation and promotes understanding that enhances work performance.

Munson (2002) also noted that workers identified good, supportive supervisors as the main source of help in dealing with stress. Experienced supervisors avoid the temptation to offer instant advice. They understand that simplistic solutions do not work and often increase the worker's distress.

### ***Barriers to supervision***

Challis (2011) names a number of barriers to supervision, including:

- lack of management support, where staff are subtly or overtly discouraged from taking the time required
- untrained or inexperienced supervisors lacking the required skills
- time limitations available for supervision
- staff lack of insight to the benefits of supervision
- lack of outcome-based supervision. A limited focus may mean practitioners are not assisted to develop new skills and solve problems.

Supervision should be targeted to the needs of those supervised and to the skillsets that will help them to improve their work

practice. This could include discussions of theoretical frameworks that help to inform practice, an exploration of feelings and work experiences, role playing, appropriate interventions and counselling techniques, discussion of work scenarios, motivational interviewing and developing ways of providing an integrated response to consumers with complex issues.

## MENTORING

Mentoring is generally less structured than formal supervision. It refers to when a nominated, trusted and experienced staff member is available to a colleague who has lesser experience. The goal is to help them to reach their full potential, building confidence and offering guidance where necessary.

Mentoring involves observing and monitoring the performance of the skill or task over time and giving constructive feedback. This feedback cycle can be performed multiple times.

One example of mentoring might involve a mentor observing the implementation of a screening and assessment tool and then providing feedback and suggestions for skill building. Another might be regular coffee catch-ups between an experienced board member and a new recruit enabling discussion of any areas of confusion about how the board operates.

## SUPPORT MATERIAL

- » *Community Sector Workforce Capability Framework Toolkit*, Office for the Community Sector (2011) Department of Planning and Community Development. [Access it here](#)
- » National Centre for Education and Training on Addiction (NCETA) 2005, *Clinical supervision: A practical Guide for the Alcohol and Other Drugs field*
- » National Centre for Education and Training on Addiction (NCETA) 2005 [Clinical supervision resource kit for the alcohol and other drugs field](#). National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia. (ONLINE) [Access it here](#)
- » Queensland Health (2009), *Clinical supervision guidelines for mental health services*, Queensland Government, Brisbane
- » The Bouverie Centre and La Trobe University November 2013, *Clinical Supervision in the Alcohol and Other Drugs and Community Managed Mental Health Sectors* <http://www.clinicalsupervisionguidelines.com.au/>

## HELPFUL TIPS

- » Having competent, capable and skilled workers is crucial for capacity building.
- » Workforce development does not just involve training, but other components such as mentoring, supervision, observation and assessment.
- » Identify supervisors and mentors from within your organisation or from outside sources.
- » Be open to all levels of staff and management receiving supervision and mentoring.
- » Ensure administrative (managerial) supervision is separated from clinical supervision.

## TOOLS

- » Tools and Template No: 2 TNA Tool

# CHAPTER 5 - WHO ELSE NEEDS TO BE INVOLVED?

## INTRODUCTION

This Chapter discusses a critical step in the process required to undertake organisational change and build capacity. That step is identifying your key partners and stakeholders. Stakeholders are the people who will be affected by your proposals and who you need to involve in the process – keeping them informed and or partnering with them more actively. They are the people who will form the ‘volunteer army’ discussed in Chapter 2 for the change you need to achieve.

## PARTNERSHIPS FOR CAPACITY BUILDING

Considerable research points to the importance of building the capacity to work in partnership, and the contribution partnerships can make to delivering better health outcomes. Often these partnerships are about how you deliver treatment or care. However building your capacity to work with stakeholders through any kind of process or project builds the kind of trust necessary to undertake other work together.

Experience has also shown that developing a strategy outlining the capacity building activities and how they are to occur in a consultative manner promotes more effective implementation. Similarly, open and honest communication throughout the process is also vital. These elements are discussed further in a later section of this manual.

As discussed in Chapter 3 capacity building is increasingly about responding to the range of needs consumers present with in a holistic way. This relies on developing collaborative, sustainable solutions. Not surprisingly, capacity building literature stresses the importance of involving a broad range of key partners and stakeholders for successful and sustainable improvements in capacity. It is equally integral to change management as we saw in Chapter 2 and applies as much in the corporate world as it does in the health and community sectors

Everyone who is involved in your organisation’s service delivery has a part. Consumers and carers and broader members of the community can potentially play a critical role. This is discussed in detail in the next Chapter.

The involvement of a wide range of staff and consumers will also assist in reducing some of the barriers that may be encountered as part of the capacity building process. These barriers are well documented, with some examples listed below. Most are

applicable to all community service agencies who work with consumers who present with multiple and complex issues:

- Many agencies are currently orientated, trained and structured to respond to single disorders/problems only.
- Despite national and state policy, some agencies continue to have service exclusion criteria based on the presence of a co-occurring problems.
- In agencies that have undergone significant restructure or alteration, staff may be ‘change-weary’ and ‘change-wary’.
- There may be a lack of understanding (and expectations) of other treatment systems’ strengths, constraints and philosophies.
- There may be a perception that this will add to already burdened workload.

## IDENTIFYING KEY PARTNERS AND STAKEHOLDERS

Exactly who your partners or stakeholders are will differ from one organisation to the next.

You may find it useful to think about what other groups you need to engage to enhance your capacity and how they could be included. These groups are likely to include:

- champions and change agents
- staff/workers
- senior leaders
- clinical leaders
- external specialists
- other agencies

Using the Stakeholder Analysis Tool (Tools and Templates No: 3) will help you to identify your partners or stakeholders. You will be able to identify who needs to be involved as well as to answer:

- Who are the specific target groups/audiences that will be affected by this change?
- Who might be able to help you the most?
- Who might present the most resistance?
- Who will be the change drivers?

Remember in any successful partnership support is a two-way street. Once you have identified who you want to be involved and support your process, you need to consider the way in which you want to involve them. For example are they part of your core

change management team? Or do you want them engaged as part of what Kotter calls your 'volunteer army'? You also need to ascertain the level and type of support you can provide to achieve this. Support for your stakeholders or partners may also represent the critical difference between participation as 'empty rhetoric' and having the real power to influence the outcomes of the capacity building process (Arnstein 1969).

Some further questions to consider:

- What partners do you need to engage to successfully enhance your organisation's capacity?
- What is their vested interest in this? What is their stake/ impact/needs in the change outcomes?
- Have you included consumer and families/significant others/ carers?
- Who would be your supporters?
- Who will present barriers? What would it take to get their support and have them working actively with you?
- Do you require support from fund holders or policy developers?
- Do you require a change management consultant to help you get started?
- Do you need to conduct some activities to align or join the partnership?
- How often does this group or partnership need to meet?
- What are the Terms of Reference for this group?
- How will the partners define success?

*A summary of consultation learnings from multi-agency partnership development Source: Ovens and King Community Health Service 2010*

## CHAMPIONS AND CHANGE AGENTS

Any capacity building and/or change exercise requires the involvement of champions and change agents.

'Champions' are the ones who believe in the change, they are flexible, and they are committed to the process of capacity building. They have superior knowledge and skills about the area in which the change is to occur. They are able to communicate effectively with all stakeholders, identify any issues and elicit strategies to overcome those issues.

'Change agents' have all the same attributes as champions. The difference is that they have responsibility for actually planning and executing implementation. They are the ones who are accountable for getting the job done. Change agents must have the trust of and credibility with all stakeholders (top down and bottom up), be resourced by the organisation and authorised to make the changes.

To effectively build capacity and manage change, it is recommended that organisations build their own networks of local

change agents with the knowledge and skills to do the following things:

- Adapt and use change tools to make specific changes
- Create positive expectations and motivate staff and stakeholders
- Get people to 'buy-in', provide support and participate
- Identify and remove barriers
- Deal with resistance
- Communicate!

## YOUR CAPACITY BUILDING CHANGE MANAGEMENT TEAM

We've already mentioned champions and change agents however you may also want to consider developing a change management team. This is your coalition for change. They are there to support, offer guidance and help drive the implementation of the change.

- Team members should represent a variety of functions, departments and levels in the organisation, while also representing a cross-section from your stakeholder groups.
- They need to have excellent communication skills, have business influence, be committed to the change, know the business and be a team player. Some change management experience would be an asset.
- The team does not have to be working on your project full time but must be able to commit some time to the project.
- The team may require some team development to provide a common understanding of the business issues that motivated the change and the vision for the future state for the organisation.
- The team need to identify roles and responsibilities in the implementation of the change plan.

## Staff/workers

Staff need not only be aware of the change process, but be actively engaged in it. They need to play an active part in the innovation, design and implementation of the process. It is important to include regular meetings and other communication forums through which staff are able to express their concerns, accomplishments and ideas.

While achieving better outcomes for service users is often good motivation for change, staff need to be made aware that there will be benefits for them as well. This may include a reduction in duplication of work, improved efficiency or better working conditions.

Staff education and training is a core tool in building capacity. It is essential that there is involvement and consultation with relevant training organisations, providers and institutions about how best to deliver the education and training your staff need. Consider consumer participation to enhance your staff training.

### Senior leaders

Senior leaders must be involved in capacity building. This may include managers all the way up to the CEO and the Directors of your Board or Management Committee. Their engagement, support and promotion of the process is crucial. Without it staff will not be convinced the organisation supports the change. With it staff will see that the process is serious.

They may need to meet with or send messages to the rest of the staff at key milestones to help them maintain their confidence in the process of change and encourage them to maintain their commitment to the process.

### Clinical leaders

A clinical leader is a person with a clearly defined role to activate, stimulate, and nurture service improvement. Successful clinical leaders have legitimacy among their clinical colleagues and are opinion leaders. Their engagement in the redesign of services will clearly help to ensure improvements in capacity are sustained.

### External specialists

Many community based agencies have been working towards working more collaboratively and holistically with building up considerable expertise. As a result they have expertise to share.

It also means there are many experts or specialists who have 'walked in your shoes'. Seek them out for mentorship and support. Their lived experience and learnings will be extremely valuable as you seek to expand your own agency's capacity.

### Other agencies

Complex needs often mean a consumer is battling multiple problems. This can include mental health and alcohol and other drug issues, trauma, homelessness and family violence. Strong working relationships between services can help promote delivery of a holistic response to the complexity of consumer needs. You will want to think about which agencies that may be key players in your capacity-building process. They could include:

- public and private mental health services
- alcohol and other drug services
- community health services
- primary health services
- police and forensic services
- housing and homelessness services
- culturally appropriate services related to your agencies catchment area
- age-specific services (youth, adult or older persons services)
- family services

- Aboriginal Controlled Organisations

### Consumers

The other members of your change management team and volunteer army are your consumer representatives. They are so important that we have devoted all of Chapter 7 to them.

### SUPPORT MATERIALS

#### Readings and resources:

- » DETERMINE Working Document (2009) *Voices from other fields*, [access it here](#), for practical recommendations on building effective and sustainable partnerships.
- » K.E. Smith et al. (2009) *Partners in Health? A systematic review of the impact of organisations and partnerships on public health outcomes in England between 1997-2008*. Journal of Public Health, Jan 30, 2009, pp. 1-12
- » Kelly Bayer Rosmarin (2015) *Harnessing Innovative Thinking* Company Director Vol 31 Issue 6 pp30-31

### HELPFUL TIPS

- » Consider involving a diverse group of individuals including those in direct service delivery such as consumers, staff, external specialists and other agencies.
- » Champions and change agents have a special role in making the planned capacity building and change actually happen.
- » Other people who should be involved include clinical staff, clinical leaders, senior leaders, other agencies and external specialists, and consumers.

### TOOLS

- » Templates and Tools No: 3 Stakeholder Analysis Tool

# CHAPTER 6 - PARTNERING WITH OTHER AGENCIES

## INTRODUCTION

At the outset of this Manual we noted that closer collaboration between agencies is being driven by a range of factors. This Chapter takes a closer look at why you should consider how collaborating with external partners might promote the development of your agency's capacity. It explores collaborations of different types that can help develop the capacity of an agency or organisation. It also looks at the importance of maintaining good relationships with government and other funding bodies.

## DRIVING PARTNERSHIPS

Most obviously together you can offer a wider range of services to consumers. Some other key ways alliances can build capacity include the strength they can add to advocacy. They can help diversify funding streams, create economies of scale, share expertise and add purchasing power. These are all attractive features.

Agencies in the Not for Profit (NFP) sector ranging from aged care to disability and health are also finding that less positive features promote closer collaboration with other agencies. For example there is often uncertainty both about ongoing funding and about how governments intend to pursue various policies. This uncertainty can make boards hesitant to invest in infrastructure, resources and new programs.

At the same time, community based organisations are increasingly required to competitively tender for the opportunity to continue to deliver their services. In many instances their small size and lack of infrastructure make it difficult for agencies to bid for, and secure the contracts necessary for survival. Limitations on the number of services to be funded in a designated catchment area exacerbate these issues.

Regardless of the drivers, partnerships can significantly enhance the capacity of each participating agency, or in the case of a merger, of the new organisation.

Collaborating with external agencies may of itself require consideration of formal change management within an agency. While many agencies wait until they are pushed by some form of crisis to consider such a proposition, you may find it useful to consider the strengths and weaknesses of your organisation. Think about how collaboration with other agencies might assist in

building your capacity to meet your own organisation's goals (Moriarty P, 2015). Then think about what kind of partnership with which external agencies you might want to pursue to achieve those goals.

## PARTNERSHIPS

Partnerships between organisations exist in many forms on a continuum. They include informal collaborative alliances and networks for advocacy and campaigns. Formal consortia and contracts might be entered into to deliver specific projects or programs. Joint governance arrangements might include joint ventures, and ultimately mergers. Terms such as consortia, partnerships or alliances are often used interchangeably in the context of integrated service delivery. While they may have different legal and contractual implications for organisations, the overall intent is to differentiate multi-organisational arrangements from single agency ones.

In the community sector these arrangements will sometimes be entered into with other not-for-profits. However, you might not want to rule out the potential for partnerships with for-profit entities. Whether you are considering collaborating with a not-for-profit or a for-profit business ensuring alignment of values between your organisations and also strategies to promote the relationship will be of particular importance. This is particularly relevant as the underlying principle of such partnerships is that it benefits consumers.

### Thinking about not-for-profit partners?

**B Corporations** are subject to a system of global certification that obliges them to meet high standards of overall social and environmental performance, legally expand their corporate responsibilities to include consideration of stakeholder interests, and build collective voice. There are currently 62 B Corps in Australia. They include Community Sector Banking; a joint venture between Bendigo and Adelaide Bank and Community 21, a coalition of not-for-profit organisations including Jobs Australia, Oxfam Australia, Scope and the Australian Council of Social Services (ACOSS).

## AGREEMENTS TO COLLABORATE

Collaboration is about working together. It provides a number of benefits for capacity building. Knowledge and expertise is pooled, and it can produce a more co-ordinated approach to service provision which ultimately results in better outcomes for

consumers. This can be at any level between organisations from management to clinician/service delivery level, and can be between agencies in the same or different sectors.

Collaboration with external agencies often requires a more formal approach than would be the case with stakeholders internal to your organisation. For example, to enhance your agency's capacity you might not only want another agency to participate in your project reference group. You might want to coordinate the delivery of complementary services with them. Other typical joint activities might include planning and developing services to improve outcomes, share information and resources and/or develop policy.

To support such ventures you might consider forms of agreements such as Memorandums of Understanding (MOUs), Letters of Intent and Heads of Agreement. The more complex these agreements are the more likely they may serve to legally bind the parties in the way that a contract does, regardless of the intention of the parties. If in doubt about this seek legal advice.

However collaboration with other agencies is rarely 'business as usual'. The greater the collaboration the greater the investments of time, resources and commitment required. For this reason the QCOSS Collaboration – Decision Support Tool includes a series of questionnaires to help community organisations consider the suitability of alternative models of collaboration and direct their efforts according to their immediate capabilities and purpose. The Tool can be found [here](#).

Another useful practice guide for cross-sector collaboration has been developed by a collaboration between the Bouverie Centre, the Victorian Responsible Gambling Foundation, a University and others. The guidelines created in 2014 are intended for broad use and can be found [here](#).

## CONSORTIA AND SUBCONTRACTING

More formal approaches to collaboration include consortia. Well-established vehicles in the corporate sector, they are relatively new to the not for profit community sector in Australia.

Before entering into any consortium all the potential partners need to understand and be clear about what they want out of it, and to carefully consider the pros and cons.

Consortia vary significantly in terms of complexity, contractual arrangements and the purposes for which they were formed. They may take time to build, particularly given that organisations are often competing as rivals for resources with limited trust. However they are generally able to be created more rapidly than a formal merger.

### **What is a consortium?**

A consortium is a model of collaboration that allows 2 or more agencies to combine their capabilities, tender for funding and deliver services without having to establish a separate legal entity when developing and delivering a tender. The primary driver of a consortium approach is that it allows for greater economies of scale, efficiency and effectiveness. A consortium can be made up of partners from different sectors and this offers a great source of competitive advantage.

There are various types and models of consortia. A completely new organisation can be created as a joint corporate venture between the partners. A limitation of this approach is that this organisation will initially have no track record or assets of its own. This may make it less attractive to funders.

Alternatively a 'lead partner' consortium can be utilised. An existing organisation is nominated as the lead agency for the purposes of contracting with the funding body(s) and others. The other partner agencies formally agree to work through the lead organisation. All partners would be allocated areas of work based on specialism and capacity. The agreement between them may involve formal subcontracts or a Memorandum of Understanding. The consortium itself does not have any legal status. They are usually led by a management or steering committee group that includes members of each organisation.

Typically, most consortia consist of formal agreements or contracts which set out the parties' rights and obligations. Like funding agreements they should include who the lead agency is, how funding is allocated, confidentiality and intellectual property provisions and provisions for dispute resolution.

#### **Advantages:**

- Relatively straightforward to establish (formed by agreement)
- Flexible - members can change their agreement at any time to suit changed circumstances
- Expiry dates can be set
- Low cost (no capital is required)

#### **Disadvantages:**

- There is a lack of permanent structure
- If you are the Lead Contractor, funding bodies may require you to carry all of the risk and the liability
- May be lack of clarity of purpose, management and structure
- If one partner fails to deliver then your reputation may also suffer in terms of future tendering
- May be inadequate beyond the limits of a specific program or service

### Questions for consortium partners

- Do each of the collaboration partners have compatible working cultures or similar values?
- As part of developing the consortium have you set aside enough time to work through problems or issues?
- Have you reviewed your practices and discussed how things will work?
- Do you have to submit 'fit-for-purpose' documentation for all the partners? Are there any difficulties related to documentation (i.e. audited accounts, trading track record, business processes)?
- What contingency plans are in place for dealing with staff changes during the contract?
- What form of governance and or [legal structure](#) will you use for your consortium?
- What sort of decision making structures have been put in place? Are they flexible/adaptable and fair to all parties?
- How will you manage disagreements in the consortium?
- How will you manage or allocate responsibilities/liabilities?
- Who owns the [intellectual property](#) rights?
- What are the implications if you end up in competition for other tenders?
- What processes are in place for shared learning?

Based on 'Working in a Consortium' Queensland Government Business and Industry Portal accessed September 1 2015 [Available here](#)

## MERGERS

Mergers in the not-for-profit sector have become more prominent in recent years. As at 2015 the Australian Institute of Company Directors NFP Governance and Performance Study found that 30 per cent of the 2700 Directors who responded had at least discussed action to merge their agency in the last year (Stuart D, 2015b).

A strict definition of a merger involves two or more organisations joining to form a completely new organisation. A key issue includes the composition of the new Board and new management team. Are they a mix of the two legacy organisations?

Consolidations that result in one organisation simply becoming part of a larger existing entity are sometimes better described as takeovers, although there may still be variety in the structure allowing the smaller service to retain some autonomy and identity for example as a subsidiary (Rawstrone 2014).

However a merger requires a lot more than discussion (Peppercorn 2013). It can't just be the CEOs in agreement, or two board members. Even a decision to explore a merger with another agency or agencies requires that their boards approve a resolution.

Exploring a merger generally involves formal confidentiality and due diligence processes to understand exactly what they might be getting into. Most boards will want data and help from an independent source to establish the benefits and costs of a merger. Some of the issues to consider include where the capital will come from for the necessary changes to systems and processes a merger will require.

Most will want to establish their own board subcommittee as well as a joint subcommittee to oversee the merger and keep their boards informed. They will also want to establish a separate process to maintain communication with members and reassure them that the merger is in their best interests. These activities all need to be well resourced (Niesche C 2015).

It should be clear that achieving a successful merger requires more than ticking technical boxes. However it would be a mistake to believe that different cultures can never achieve a good working model (Stuart D 2015a). What is important is that the organisations involved put serious time and energy into preparing and presenting the case for merger and do not rush the process. A focus on change management as well as building capacity is clearly important.

Three emotionally-charged hurdles that non-profit managers must overcome to create successful mergers have been identified. They include: getting the boards aligned, finding roles for senior staff, and blending the brands. International research and practice suggests that undertaking a due diligence process that overcomes these hurdles may increase the likelihood that a merger will succeed ( Smith Milway, Orozco, & Botero, 2014)

## GOVERNMENT AND OR OTHER FUNDERS

Maintaining a good, productive relationship with government departments is essential for any funded organisation, even in times where significant change is not on the horizon.

Regular communication with relevant department and ministerial officers is invaluable. The more familiarity these officers have with your agency the more confidence they are likely to have in your ability to deliver. They are also more likely to be willing to provide useful advice or to participate in structures such as a reference group for your capacity building process.

Develop a knowledge of the structure of the department, and the portfolios and responsibilities of the staff who are involved. Where possible also develop a knowledge of the approachability of each staff member; who the best person is to engage in conversation and their level or seniority, what communication methods are best (meetings, letters etc...) and the language to frame the approach in. Agencies and organisations can also raise their public profile and attempt to influence public policy through regular contributions to submissions and parliamentary enquiries where appropriate.

Obviously direct approaches will not be appropriate where departmental officers are responsible for specific tenders or other competitive processes such as service commissioning. Probity processes will be in place to ensure that the process has integrity and that no particular agency is favoured.

Judy Pfeifer (2011) suggests that the key to working with government involves directly pitching the importance of the cause:

- “Match your organisation’s priorities with the government’s priorities. Common ground is your entry point in building your relationship with the government
- Be solutions-driven. Frame your concerns in a way that’s accessible, so that a politician can understand without specialised knowledge.
- Keep cultivating your relationship with the government. It isn’t enough to simply get officials to know who you are – you need to make yourself useful to them
- Form coalitions to strengthen your efforts. Identify which organisations are going to oppose you; these are the groups you will need to try to bring onside
- Build relationship outside government. Raising your profile is a crucial part of any government relations strategy”.

## SUPPORTING MATERIAL

### Readings and resources:

- » Department of Planning and Community Development (2012) Community Sector Shared Services: Why consider shared services?
- » Part 1: Why consider shared services? The advantages, disadvantages and challenges of the four-part guide to establishing shared services in the community sector.
- » Part 2: Are shared services right for you? An evaluative framework
- » Part 3: How to establish shared services – A step-by-step guide
- » Part 4: Case Studies
- » VicHealth (2011), The partnerships analysis tool, Victorian Health Promotion Foundation, Melbourne. This resource provides for organisations from the assessment phase of relationship development right through to evaluation of effectiveness. [Access it here](#)
- » B corporations [here](#)
- » NSW Council of Social Services (NCOSS) Formalising Partnerships Kit prepared by Tim Childs Consulting June 2008 Updated May 2009. [Access it here](#)

- » Victorian Council of Social Services (VCOSS) Practice Guides (2008):

1. Preparing to partner
2. Commencing the partnership
- 3 Sustaining the partnership
4. Partnership governance, models and leadership

[Access it here](#)

- » Pro Bono Australia Online ‘Community Sector Banking Certified as a B Corp’. News Service 1 July 2015. [Access it here](#)
- » Pro Bono Australia Online “More NFP Boards Tackle Mergers & Collaborations – Report” News Service October 23, 2014. [Access it here](#)
- » Queensland Council of Social Services (QCOSS) (2014) Community Door eTraining and Collaboration – Decision Support Tool. [Access it here](#)

## HELPFUL TIPS

- » Ensure you consider the needs, strengths and limitations of all your key partners.
- » The development of partnerships between agencies can greatly enhance the capacity of each participating agency.
- » There are a range of types of partnerships (for example, MoUs through to contracts, consortia structures and mergers). Careful consideration needs to be made as to which type of partnership will best suit your agency, and what steps need to be undertaken to make it work .

# CHAPTER 7 - CONSUMERS, CARERS & COMMUNITY

## INTRODUCTION

When we talk about capacity building and change management we often immediately think about ensuring the ‘buy in’ of key staff and senior management. However, community organisations are created to meet a need in the community. It is therefore logical that the people experiencing those needs should have a large voice in the design of processes which will ultimately impact on them. This Chapter discusses the need to involve consumers, their families and/or carers, and indeed broader members of the community in the change process.

### WHY ARE CONSUMERS SO IMPORTANT?

For starters:

“Well co-ordinated care that focuses on the individual needs of the patient is much more likely to result in better outcomes for the patient, clinician and the system, particularly if it reduces need for hospital care”. (Wells 2015).

### WHO ARE CONSUMERS AND CARERS?

Within the health and community service sectors there are many different words which can describe people who access services, and the language used will often depend upon the type of service provided. For example, people accessing medical services will usually be called “patients”, and counsellors will often refer to their service users as being “clients”.

“Consumer” is a term utilised in this manual to encompass all of those individuals who might use a service. The term ‘carer’ has been used to refer to other important stakeholders who might include family members of the person accessing the service, or any other significant people in their lives. Carers might have contact with a community service through their relationship with the primary service user. They are also likely to have support needs of their own arising from their caring role and to be accessing services directly themselves.

The term consumer can also refer to other members of the community who have a stake in the services provided by an organisation. The European Union has adopted the view that ‘Building on the work on the Citizens’ Agenda, community health policy must take citizens’ and patients’ rights as a key starting point (European Commission 2007 cited in European Patients

Forum 2010). This includes participation in and influence on decision-making, as well as competencies needed for wellbeing, including health literacy”.

In Australia and other countries the concept of citizen participation underpins the development of networks of people prepared to serve as consumer or community representatives in many community settings. They may have experience of a particular social or health problem or they may simply have an interest as a citizen in the delivery of community services. With the backing of a consumer organisation, these people will often have some training in their role and may bring a more strategic contribution to their involvement in your change management exercise.

It is possible to separate out these different types of consumer roles. Thinking about what kind of consumer input you are seeking will help ensure that you are clear in the expectations you have of the consumers you invite to participate. Regardless of whether you involve consumers as individual service users, as community members or as representatives from consumer organisations, they are likely to bring valuable perspectives and ideas that others involved may not have thought of.

Consumers, their families and carers are often willing, prepared and able to be part of the policy and decision making at all levels of service design and implementation. This includes strategic planning right through to service delivery. The participation of consumers and families/significant others/carers is not just an idea, it is an active imperative.

As you begin working towards building your agency’s capability, now is the time to include consumers and families/significant others/carers in all aspects of your capacity building process.

Here are some of the types of things that consumers and families/significant others/carers say. These comments come from a regional health service consumer and carer forum. You may also find it useful to look at other consumer and carer commentary and resources as listed at the end of this chapter.

1. We know what works for us.
2. We would like to be included in planning.
3. Please look at us, the consumer, as a whole person.
4. We only want to tell our story once.
5. We do not want to be transferred from one place to another.
6. We would like you to work together with all the other

agencies that need to be involved in our care.

7. Please help us with our children and other family members, so that their needs are met and they understand what is happening.

8. Although you may not understand my culture, please be sensitive to my needs regardless.

9. My journey may not fit your timeframes, but it does fit mine.

10. I would like a service that fits in with my goals and needs rather than me having to fit in with what the service offers.

Victorian, Hume Health Region: Consumer and Carer Representatives Forum, March 2011

## WHAT IS CONSUMER PARTICIPATION?

Consumer participation can mean different things to different people. There is now fairly widespread agreement that consumers should be involved in treatment or other decisions that directly affect their lives or health, or about giving feedback about their experience of a service:

*“...the process of involving consumers in decision-making about a particular service including components such as service planning, policy development, priority setting and addressing quality issues in the delivery of those services”*  
HomeGround Services and Rural Housing Network Ltd.  
(2008)

However, a large body of literature demonstrates the importance of consumer, carer, and indeed community participation at all levels of an organisation. This might include positions on boards or committees of management, through to participation in project advisory committees, as consultants for quality improvement processes, in recruitment and staff training and in service reviews. More broadly consumers can play key roles as advocates in government program development and evaluation.

Some of the ways in which consumers, carers and the broader community can participate in their own treatment include service planning, development, delivery and evaluation. They can also include:

- policy and research
- priority setting
- quality improvement processes
- education and training of professionals and other groups engaged in your capacity building processes

The value of involving consumers meaningfully in decision-making whether about their health care and treatment or in broader policy, planning and service delivery lies in the growing recognition and evidence that consumer participation:

- positively influences an individual's health outcomes if they are given quality information and are actively involved in decisions
- improves quality and safety by helping to design services that meet consumer needs
- provides feedback to drive service improvement
- enhances accountability by openly and transparently reporting on performance to consumers

Victorian Auditor-General (2012)

National Standards for Mental Health Services have required attention to consumer and carer participation in planning, service delivery, evaluation and assessing the quality of programs since 2010. These levels of engagement are also reflected in National Safety and Quality Health Service Standards which apply to health services more generally, introduced across Australia from 2013 (ACSQHC, 2012).

Traditionally, health and community services have tended to see consumers as passive recipients of care. This means implementing consumer participation requires an ongoing change process, involving for many services, a cultural shift. That shift involves recognising the consumer as an actively engaged participant.

Key consumer bodies in Australia include Consumers Health Forum of Australia. Along with agencies such as the Health Issues Centre, and consumer organisations targeting specific groups such as the Council on the Ageing (COTA) you will find they have an array of resources. Access these resources for more ideas on how you can engage consumers more effectively within your service.

## Levels of participation

Different modes of participation are commonly represented as a 'Ladder of Participation'. The ladder builds on the original work of Sherry Arnstein (1969). Her original articulation of the ideas behind the ladder is still worth reading. The steps on the ladder range from 'no participation' through minimal levels (where consumers receive information but have little say in decision making) through to joint planning and ultimately to citizen control.

Table 31: Ladder of participation

Degree	Participant's action	Overview
High	Have control	Organisation asks community to identify the problem and to make all the key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Have delegated	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions, which can be embodied in a plan it can accept.
	Plan jointly	Organisation presents tentative plan, subject to change and open to change from those affected. Expects to change plan at least slightly and perhaps more subsequently.
	Advise	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Are consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so administrative compliance can be expected.
	Receive information	Organisation makes a plan and announces it. Community is convened for information purposes. Compliance is expected.
Low	None	Community not involved.

Adapted from: Brager & Specht (1973)

For others, participation options are more usefully considered as a continuum or even a grid of options that:

- is flexible
- can be applied as a whole or in parts without judgment about 'more' being 'better'
- recognises that people and workers and groups have different skill levels and experience and so they may access the model in different ways
- acknowledges that more complex participation strategies should be based on, and implemented in conjunction with, simpler strategies to improve sustainability

These approaches acknowledge that consumers themselves are diverse and demonstrate widely varying capability to participate. (Australian Infant, Child, Adolescent and Family Mental Health Association (2008)

Clarifying the ideas and assumptions that are guiding your practice of participation is an essential undertaking. Participation can operate at different levels and may be motivated by

contradictory intentions. For particular groups their preferred mode of participation may also relate to their state of health, their age and or cultural influences. Agendas are varied. Consumers can demand or refuse participation for a range of reasons that may or may not be similar to what your organisation has in mind.

This is why it is important to consult with consumers at an early stage to establish how best to involve consumers and what your organisation's capacity is to facilitate this.

Some questions that might need to be addressed as part of this process include:

- Who are the consumers we want to engage?
- How do we recruit them?
- What role do we want them to play? Is it going to be an informal one, or do we need to put more formal structures in place such as Position Descriptions?
- How are we going to orient and support our consumers?
- Can we reimburse the costs of their participation?
- How else can we acknowledge or celebrate their participation?

Depending upon what role you would like consumers and family/significant other/carer representatives to play (whether in an employed, voluntary or advisory role), they will also require training and development to enable them to be skilled and confident in achieving their roles.

### Meaningful participation

Participation must be meaningful if it is to be at all useful. Engaging consumers in decision making whether about services, policy, education or research may be a challenge. It requires service providers and professionals to be willing to reflect on and if necessary, change their current work practices. And it is worth doing.

In *Straight from the source: a practical guide to consumer participation in the Victorian alcohol and other drug sector*, Miriam Clarke and Regina Brindle (2010) suggest some guidelines to ensure effective consumer participation. They are useful to follow well beyond the AOD sector:

- Be clear about your organisation's capacity to involve service users and to respond to service user concerns.
- Be careful not to promise what you can't deliver.
- Ensure that productive consumer participation is supported by management at all levels.
- Be prepared as an organisation to listen to feedback, make decisions and accept any changes.
- Understand and manage conflicts. Enhanced consumer participation can mean that tensions emerge from time to

time. This is okay and is likely to lead to better quality service and improved outcomes in the long term.

- Encourage dialogue and trust in your partnerships with service users. Trust is built by transparency and consistency.
- Engage service users early in the process – even in the process of deciding how your organisation will engage service users better.

## SUPPORT MATERIALS

### Suggested readings and resources:

- » Victorian Auditor General (2012) *Consumer Participation in the Health System*, Victorian Auditor General's Report
- » The Association of Participating Service Users A service area of the Self Help Addiction Resource Centre (2010) *Straight from the source: A practical guide to consumer participation in the Victorian alcohol and other drug sector* [Access it here](#)
- » Australian Commission on Safety and Quality in Health Care (ACSQHC), National Safety and Quality Health Service Standards (September 2012) Sydney, ACSQHC (ONLINE) [Access it here](#)
- » Commonwealth of Australia (2010) *National Standards for Mental Health Services*. (ONLINE) [Access it here](#)
- » European Patients Forum (2010) *The Value+ Handbook for Project Coordinators, Leaders and Promoters on Meaningful Patient Involvement*. [Access it here](#)
- » Health Issues Centre. Getting started: participation frameworks for healthcare organisations. [Access it here](#)
- » Consumers Health Forum of Australia (2015) "Unique and essential": a review of the role of consumer representatives in health decision-making. [Access it here](#)
- » COTA Australia and COTA SA (2013) *This is our space - Ageing with Disability, Information, strategies and tools to support the inclusion of older people with disability in mainstream, community-based activities*. [Access it here](#)

## HELPFUL TIPS

- » Involve consumers from the start.
- » Consumers have a lived experience of the service system which provides them with a wealth of knowledge and ideas about what improvements should be made.
- » Consumers present with a range of skills, and with the appropriate support may be able to participate at high/senior levels of decision making .

# CHAPTER 8 - THE CAPACITY BUILDING PROCESS: GETTING STARTED

## INTRODUCTION

The previous chapters discuss key stakeholders and the importance of effective partnerships with them as elements of successful capacity building. Engaging these key partners at the earliest opportunity and at a meaningful level is important. This Chapter discusses other key elements of preparation that will get you started on the journey to build your organisation's capacity.

## CONFIRM AND DEFINE THE NEED FOR CHANGE

Before you can make any specific plans, you need to establish the need for change. It is useful to be aware of the core issues and address obstacles early so that you can be clear about what you need to address and think about how to go about it.

This requires understanding where your organisation and staff are in regard to capacity and capability now. One way is to do an audit. The aim is to establish baseline information about how ready your organisation and its staff are for change?

There are many different types of tools available for your audit, and their relevance will also depend upon which area of your organisation (program and/or level of management and/or clinical practice) is being explored.

So why does your organisation need to do some capacity building? You will find that your baseline audit will provide you with some of the answers. It will show those areas of the organisation which are not performing as well as they could be.

Through effective two-way communication with consumers and staff and the results of the audit you will be able to identify change that needs to occur and help define the purpose and urgency of the change.

This is likely to involve providing improved services that better deliver the outcomes people want. However without a sense of urgency it may be difficult to gain the level of agreement and resourcing required for action.

## UNDERTAKE A BASELINE AUDIT

The process for undertaking a baseline audit is relatively similar across organisations, and generally involves the following steps:

### 1. Planning your audit:

- Are there existing objectives and a vision for change?
- Do we need terms of reference?
- Who will conduct the audit, and what skills do they need?
- What tool/s will be used?
- What is the scope of the audit?
- What data do you need, and what are the best data collection methods? What instrument will you use?
- What will be the cost, and what resources (financial, infrastructure, external assistance) do we need?

### 2. Implementing your audit:

- Select team members to use the data collection tools
- Compile the data you have collected
- Analyse the data
- Draw your conclusions, and make recommendations about how to address any gaps and problems you have identified

Examples of audit tools are found in Tools and Templates No: 3

## GAIN AGENCY ENDORSEMENT

Sustainable change is best delivered from both the top down and bottom up. You will create a firm foundation to build upon if you include all layers of the agency. Think about gaining the endorsement of the need for change and then the development of a vision by the Board of governance as well as staff. Then consider how you might develop a vision shared by multiple agencies.

## CREATE A REFERENCE/ADVISORY GROUP

An effective way to involve stakeholders as partners from the outset is to set up a reference or advisory group. A reference group also helps generate and maintain the sense of momentum required to achieve change.

In addition to enabling stakeholders to be directly involved through the life of the project, it brings additional skills, expertise and direction to the project. As identified, members of the reference group may include experts from other agencies, other sectors or even academics with experience in research and its translation into practice.

Terms of reference typically describe the purpose and structure of the group, and generally include the following:

- Purpose/role of the group
- Membership – who will participate and how many will there be in the group?
- Structure – will there be any sub-groups convened and what working approach will be adopted?
- Meetings – how many meetings will there be, where and over what time period?
- Accountability – who will the group report back to on activities?
- Confidentiality – what information can be shared and by whom?

Reference/advisory groups are not necessarily the same as your capacity building change management team, however at times they might undertake the same tasks, and may involve some of the same people. A capacity building change management team will have a much wider focus though to cover all areas of the organisation where change is to be implemented. Your reference group is also likely to meet less frequently.

## CREATE A VISION

Creating a vision early in the change process and making it public is important. Using it in conjunction with the evidence from the audit will help gain broader agency and stakeholder endorsement and buy-in.

A vision statement is a vivid description of a desired outcome. It inspires, energises and helps you create a mental picture of how the system will look, feel, and function when providing an effective response to the complexity of needs people seeking your agency's help may present with.

Remember that the audience for the vision is broad. It needs to resonate with the staff and management but also other stakeholders including consumers and other agencies involved in their treatment or care. This means it is probably wise to seek broad input to the development of your vision. Again these people should include those who:

- Already use or work with your organisation
- Have the best interests of the organisation at heart
- Will challenge your thinking and that of your organisation
- Bring a different perspective.

It is preferable that the development of your vision involves all your stakeholders. At the very least it needs to be tested with the stakeholders involved in your reference group. A more inclusive approach would ensure the vision is open to further development by the reference group with input through agreed strategies for consulting stakeholders more widely.

At the very least your vision needs to be communicated to all

stakeholders. You might find seeking formal endorsement of the vision promotes a commitment to working together to deliver the improved capability it promises.

## IDENTIFY YOUR LEADERSHIP TEAM

We have already discussed the need for a guiding team including change management champions and change agents to lead your project. Champions can publicly support and sustain momentum for the change process or project.

Change agents will be more effective if they are clearly identified with specific leadership roles. They require meaningful tasks and responsibilities endorsed by management with clear pathways of reporting and authorisation. When they are clearly defined, communicate the roles of your change agents to all managers and staff.

Typically the role of a change agent has several components. They can:

- Coordinate the project implementation
- Develop the strategy and coordinate the plans within it
- Provide coaching and feedback to staff and managers
- Ensure communication of project progress to all staff
- Ensure milestones of progress are celebrated
- Ensure the project is adequately resourced.

Change agents can help legitimise their role by being the key people who talk about the process, report against outcomes, consult with staff and managers and monitor key performance

## COMMUNICATE AND ENGAGE

Right from the start, communicate! At all stages of change management and capacity building, communication is the key. Establishing a stakeholder reference group and project management team will help. Some further critical steps are outlined below.

### HEAR BUT ALSO LISTEN

We all know that communication is not just about talking but also hearing. It involves active listening and reflecting on the response you receive. This is often described as having a two-way conversation. The importance of open and two-way conversations with all stakeholders cannot be underestimated.

Remember the most effective format and style of communication will differ depending upon what best suits the stakeholder you want to engage. For example, effective communication throughout your organisation is essential to support the change that building capacity involves. Staff will need to be informed of the change and the process. Equally important they need to feel they have a part in the process.

This will include opportunities to voice concerns and to influence the development and staging of the process. Staff groups and clinicians may have formal representatives on your reference group. You might want to consider additional strategies for keeping all staff informed. Senior leaders and your agency's Board will need to be fully briefed from the start. Updates as the changes take place will also be required to keep them engaged.

Similarly, consulting all the stakeholders you have identified as needing to be engaged will require open two-way communication. Take the time to develop a good Consultation and Communications plan as discussed further in the next Chapter.

### TIPS FOR EFFECTIVE COMMUNICATION

- Consider what will need to be communicated and by whom?
- Establish a formal consultative process that involves representatives of all stakeholder groups. Determine what is negotiable and what is not and why this is the case.
- Keep people informed of ongoing changes as often and using as many channels as possible – when, why, how? Work collaboratively with opinion leaders, sponsors and funders, stakeholders and staff when developing the communication process. It is important to allow all those involved to determine what this should look like.
- Emphasise messages by using credible, respected spokespersons that are trusted and liked.
- Top down, bottom up communication should be the same. Everyone gets the same message.
- Consider what you would want to know (usually staff would like to know what is in it for them and how can they contribute).
- Build in a means by which those that are affected by the change have a forum or opportunity to raise concerns early. This ensures their fears are heard and addressed before they have a chance to grow.
- Build in a 'no secrets/no surprises' rule wherever and whenever possible.
- If you don't know something, say that you don't know.
- If you don't act on people's suggestions, make sure you explain the reasons why.
- Allow yourself to be human and make mistakes. Deal with the mistake, acknowledge it, apologise and make amends.
- Celebrate and promote success. Take opportunities along the way to celebrate small achievements as well as the major milestones.
- Acknowledge all stakeholders and their input in key documents, presentations, reports and communications.

### SUPPORT MATERIAL

#### Suggested reading:

- » Blackman, D., O'Flynn, J. and Ugyel, L. (2013) *A Diagnostic Tool for Assessing Organisational Readiness for Complex Change*, Australian and New Zealand Academy of Management (ANZAM)

### HELPFUL TIPS

- » Include all key partners from the beginning and where possible establish a reference group to assist with driving the project.
- » Ensure both top-down and bottom-up involvement by gaining agency endorsement.
- » Be clear about what outcome you want
- » Properly measure how ready your organisation is for the change before you start
- » Communicate, communicate, communicate!

### TOOLS

- » Tools and Template No: 4 Agency audit tools

# CHAPTER 9 - PLANNING YOUR STRATEGY

## INTRODUCTION

We have discussed some of the elements that will be critical to the success of your change management and capacity building strategy. Planning your strategy will also involve a number of components or sub-plans. They are the subject of this Chapter.

## DEVELOP YOUR STRATEGY

Having engaged your stakeholders, completed your baseline audit, and gained the endorsement of your agency for the purpose and vision of the change you are seeking, you are now ready to develop the scope of the change process. Good planning in the beginning can save you a lot of time and trouble as the project progresses.

The strategy will include general principles that will guide implementation. It will also establish the specific activities to be completed, include indicative timelines and identify the persons responsible for key aspects. It will also include some detail of how you will assess whether it is on track and enable ongoing evaluation of outcomes.

## TOOLS

» Tools and Template No: 5 Plan

## THE PDSA CYCLE

There are a range of project management approaches and tools that can be used to support change management. Many of these use differing names and language to describe each of the stages involved. However the process will usually owe a considerable debt to the 'PDSA cycle' first popularised through the work of W. Edwards Deming (Moen and Norman, 2010).

PDSA stands for **Plan – Do – Study – Act**

(or C for 'Check' if you prefer). PDSA is in essence a systematic approach to implementing and learning from change. The cycle involves the application of a systematic approach to innovation, originally conceived as a model for continuous quality improvement. Just as it revolutionised manufacturing in post-war Japan, this systematic approach has been gainfully adapted in many other sectors including health.

The PDSA cycle can be used in all aspects of your strategy. Using the cycle can assist in ensuring quality control across all the components of your strategy and or sub-plans you develop.

## WORKING WITH THE PDSA CYCLE

**PLANNING** is about developing your strategy and the various component plans that contribute to it. This is about working out what it is you intend to do and why before you do it. It includes some of the steps we have already discussed such as identifying your goal or purpose, and defining your measures of success.

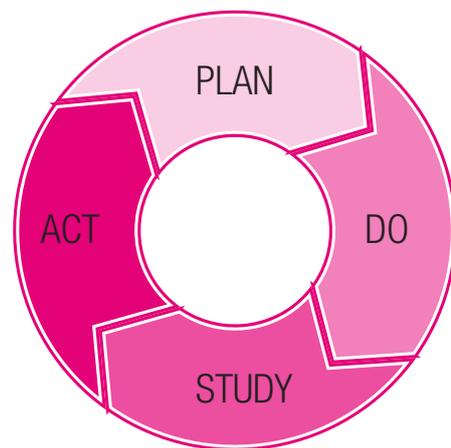
**DO** is about implementing the strategy and plans you have made.

**STUDY** is about reviewing and reflecting on what happened.

**ACT** is about what you do with the findings, preferably integrating the learnings generated by the entire process. These can be used to adjust the goal, change methods or even to support a decision to go in a completely new direction.

The PDSA cycle works best if at the end the participants repeat steps 1 and 2 again, with new information and knowledge. In other words you repeat another cycle of Plan – Do – Study – Act ... followed by another ... and another ... and so on. With each cycle, you cannot help but improve your organisation and its systems.

Figure 3: Plan – Do – Study – Act cycle



Many organisations tend to do only part of this cycle, most often the 'Plan – Do' phases. The 'Do' phase is where organisations are often most comfortable. There's a lot of activity, all of which is seen as 'the real work'.

'Plan' is usually at least acknowledged. Organisations know that planning is important and try to do it ... or mean to ... when they 'get around' to it ... when they 'find the time'.

Where many organisations fall short is in the other half of the cycle: 'Study – Act'. An organisation may Plan and then Do. Often what's lacking is making the time to review what happened and

then to take action that is responsive to the results.

Some organisations may even produce a plan but then rarely use it or apply it. They don't make time at intervals to review their plan and compare where they are now with where they planned to be.

It's only when an organisation learns to place its attention on all of the stages of the cycle that it will start to experience major improvement. Highly successful organisations put equal attention on all four aspects of the cycle and practice them all, without emphasising any one to the exclusion of others. They understand that this apparently simple tool is incredibly powerful if used correctly.

## TOOLS

» Tools and Template No: 6 PDSA Tool

## ACTION PLAN

The Action Plan for your strategy is your master plan. It lists either the core activities or in larger projects summarises the sub-plans that the strategy will involve. This will include for example the activities you need to undertake with your stakeholders to ensure they continue to feel well supported and engaged. This is all about creating what Kotter (2015) calls the 'volunteer army' you will need to step up and help you do what needs to be done.

Your plan also needs to empower action to remove the barriers you identify. You might identify some of these through your initial audit. As you roll out the communication and consultation processes (below) you are likely to identify others. Your plan of action needs to be nimble enough to adapt to what you find as needed. Equally important to maintaining the momentum of your overall strategy, your Action Plan will include key milestones at which you can celebrate wins.

It will detail who is responsible for what, and the timeframes for each component of the project to be rolled out. In a large project you will need separate plans for some key components. These are discussed in more detail further on.

## SUPPORT MATERIAL

» Tools and Template No 7: Action Plan

## COMMUNICATION AND CONSULTATION PLANS

Communication and consultation make vital contributions to the success of your strategy. They are crucial to engaging your 'volunteer army' and can warrant detailed plans of their own. When developing communication and consultation plans, it is important to create reporting protocols specifically for developing capability.

Identify who will be the responsible member from the project team to have overall responsibility for rolling out communication and who will be responsible for undertaking the consultation activities. If you have separate communication and consultation plans make sure that both consider communication and consultation with all relevant stakeholders. For example, in addition to consumers, staff, other project teams and key partners you may also want to consider your funders, other sectors, service systems and the broader public.

Just as your stakeholders are varied, attention to the way each of these groups prefers to communicate or to be consulted will be important. It is likely you will need to use a variety of consultation techniques. You may need to consider use of translated materials or interpreters. Elements of the Consultation and Communications plan may involve forums and workshops or a range of other communication activities with clinicians, other staff and managers and other agencies. Use of online strategies and social media may be an important component of this plan. You should also consider the potential interest of the media in what you are doing.

Over the course of your strategy you can use these activities with stakeholders not only to inform them of your plans but to engage them to:

- Seek stakeholder ideas and support
- Update them on the process
- Hear about any issues
- Brainstorm solutions.

*Throughout the process of developing the plan, ensure that all stakeholders are aware of the progress and that there are mechanisms for them to clarify any areas and have input into the development of the plan.*

## TOOLS

» Tools and Templates No: 8: Communication and consultation Plan

## TRAINING PLAN

Keep in mind that all staff will be at differing levels of readiness and capability. It is known that to effectively build capability and capacity, you will need:

- Good quality educational programs for workers
- Quality supervision and mentoring
- An infrastructure within your organisation that supports the development of capacity and capability.

Any training plan should also include supervision and mentoring – see Chapter 3.

## STAFF

Ideally, training should be tailored to the needs of the individual. Individual capability checklists can be valuable for staff to identify their training needs and inform the training plan.

## KEY PARTNERS

Your agency might want to undertake some joint training with key partners. This will help develop shared ownership of the ultimate vision as well as a practical way of gaining greater understanding of how each agency currently works, its culture and your potential contribution to greater capacity within each other's agency.

## CONSUMERS AND CARERS

We have discussed the importance of consumer participation in your change management processes. Inclusion of consumers in the development and delivery of education and training for staff and other stakeholders will also assist in developing your organisation's capacity.

The objective is better understanding of the service system from consumers' lived experience. Similarly the inclusion of consumers in the training of clinical leaders, managers and boards of directors will help expand the mutual understanding of the different challenges they face between your organisation's leaders and consumers. This helps to break down barriers and facilitate change.

## BUSINESS SYSTEMS PLAN

It is vital to ensure that your organisational infrastructure will support and sustain the change you envisage. You will want enough financial and human resources to implement your strategy. Equally important are good/strong policies and procedures.

Your business systems plan will need to outline steps you will take to ensure your organisation has adequate resources and infrastructure to achieve your goals. Most capacity building strategies and activities will also have an impact on current policy and require the revision of your organisation's policies and procedures. Policy adaptation and review should be considered as a core part of your implementation strategy. It will help to embed the cultural changes you have achieved in the organisation for the long term.

This may include planning to:

- Include new processes in staff orientation packages
- Embed capability in staff appraisal checklist as a review mechanism

- Ensure the strategy is listed on key meeting agendas
- Embed changes into all relevant policy and procedures
- Institute an annual system to update training for all staff
- Identify and remunerate or resource leaders
- Update staff job descriptions with any changes in core competencies
- Monitor and update quality assurance mechanisms (for example, pre and post capability audits, policy review and updates)
- Change policy and procedure

Your business systems plan will also include:

- Costs and timelines for implanting the strategy
- A list of possible resources that are available or required
- Agreements with other agencies (for example, partnership agreements or MoUs)

## SUPPORT MATERIAL

### Suggested Readings:

- » Moen, R. D., and Norman, C., (2010) Circling Back: Clearing up myths about the Deming cycle and seeing how it keeps evolving, QP, November. [Access it here](#)
- » Kotter Institute 8 Steps to Accelerate Change in 2015. [Access it here](#)

## TOOLS

- » Tools and Templates No: 9 Framework checklist for implementing change and/or projects

## HELPFUL TIPS

- » Good planning forms the basis of all capacity building activities.
- » Develop sub-plans for all the areas that your activities will cover.
- » A good example of a systematic approach to implementation of change management and capacity building is the PDSA cycle.

# CHAPTER 10 - IMPLEMENTING AND SUSTAINING YOUR STRATEGY

## INTRODUCTION

Now it is time to put your agreed plans into action. The various aspects of the plans will have differing timeframes. However you will find that momentum builds as people try to fulfil the vision, while fewer and fewer resist change.

With your strategy under way you can also take steps to ensure the sustainability of the changes you achieve and the capacity you develop. This Chapter discusses some of the steps that help 'make change stick'.

## ANCHOR IN THE CHANGES

We have already noted that effective policies are the foundation for consistent quality practice in service delivery. Implementation of your business plan and revision of your organisation's policies as part of your strategy will be critical to anchoring the changes you have created in your organisational culture.

Remember that existing structures and mechanisms for consumer and family/significant other/carer input into the planning and evaluation of services will need to be reviewed to ensure that they reflect these new directions.

Comprehensive policies ensure that:

- All stakeholders have the same understanding and expectations about what happens in the agency
- Staff have a reference point where agency expectations are articulated to guide practice

## COMMUNICATE AND CELEBRATE

As always regular two-way communication is necessary to keep all stakeholders engaged and committed to your vision. When you have implemented changes and your policies have been updated, all staff and stakeholders will need to be informed and supported to promote effective implementation.

In addition to normal meeting and communication processes or even more formal means such as staff in-service activities, less formal activities can often be very effective in embedding change. Don't wait until you feel the implementation phase is over. Think about creating opportunities to celebrate along the way as key ways to reinforce the changes that have occurred and to maintain commitment to further improvement.

## *Empower action by removing barriers*

## PLAN TO MONITOR

Before you implement your strategy and plans, make sure you know how, when and who will be monitoring the roll out of various aspects of the change process and its outcomes. Build this into your Action Plan. Report on it regularly to your reference group, your organisation's Board and as part of your broader communications with stakeholders.

Monitoring is vital. You can expect that not everything will go smoothly. Problems will arise. It is best if you are able to catch them early and intervene before they escalate. Completely unforeseen events might have affected your results for better or worse. Similarly with hindsight you might realise that your plans didn't cover all the areas that needed to be covered. Use your Reference Group and Change Management Team to offer support and guidance about how you might need to adapt your plans as your strategy rolls out.

Tools you may find useful to facilitate monitoring include training reports and evaluations of activities and plans within your strategy, staff and consumer satisfaction surveys, and dashboard reports that help you review progress at a glance.

## EVALUATE

Monitoring is primarily about checking whether you did what you said you would do. However we have noted that you will also need to adapt your plans as you go along. Evaluation is a formal review of the original strategy and plans that allows your next strategy to be developed and then implemented specifically taking these findings into account.

The PDSA cycle assumes evaluation of both the process and its outcomes. However don't wait until you feel you have implemented your strategy. Think about and develop your evaluation framework from the start. Build the collection of your evaluation data into your Action Plan. In a large project this might include the design of systems for the collection of the data.

Identifying what you want to know at the outset will help ensure you collect the right data along the way to answer those questions. Some questions you might want to ask include:

- Has the vision been achieved or is it closer to being achieved?
- Is there a positive change in the results of the audits?

- Are staff and consumer satisfaction surveys reflecting a positive change?

Compare your progress against your baseline. Re-institute the audit tool you selected at the beginning of this process.

Remember that the audit is a quality activity that will provide you with the following comparative data from your baseline:

- Evidence and an argument for the need to apply capacity building in an ongoing manner
- Pre and post-capability measures showing growth as you implement a plan
- Identified achievements, hiccups and barriers – this information will influence priority areas to focus on for future planning purposes.

**As with the pre-audit, it is essential that the review audit process is open and that the results of the audits are communicated to all stakeholders.**

*Make sure you use the **same** audit tool you selected in the beginning of this process to ensure you are comparing apples with apples.*

When interpreting your audit results, there are a couple of things to be aware of. It is important to remember that many agencies find their initial audit is often scored quite 'generously'. Then, when a follow-up audit is conducted, the scores may not appear to have moved greatly. It is common for the second and third audits to be more true to context. To limit the chances of this anomaly occurring it is often worthwhile recruiting someone external and independent to undertake the audit.

## MEASURING OUTCOMES AND EQUITY

Most agencies are familiar with measuring components of service delivery. Measuring both the inputs (what was put in), and the outputs (what was produced) is important to demonstrate efficiency. They are indicative of program functionality (e.g. how many consumers were seen for financial reporting).

What you will also be interested in is whether the service actually improves aspects of consumers' lives, and by how much. This means you need to consider outcome measures too. Without an outcome focus many organisations do not really know if they are meeting their very own aims and objectives, since these often involve statements about serving and meeting consumer needs.

Outcome measures usually relate to areas such as an improvement in consumers' health and wellbeing as a direct result of treatment. Examples might be a reduction in substance use, reduction in mental health symptoms, improvements in relationships, access to stable accommodation, or return to work or study.

The development of quality frameworks in the health and community sectors and an increased focus on accountability to stakeholders are further reasons to develop systems that can monitor outcomes and whether the programs delivered have been equitable.

In other words, you may be asking yourself 'has access improved and for whom?'

Organisations that identify who most needs their services and then use outcome measures that meaningfully relate to the goals of those people can have more confidence that they are having a positive impact. The impact will be not only in those individual's lives, but also in the broader community. In addition to this, data about positive outcomes achieved at the service delivery level is the kind of evidence that funding bodies often look for. It places agencies in a better position to seek additional resources.

There are a range of frameworks you can use to underpin your approach to evaluation, including program logic (Department of Human Services 2013). This is a commonly used model that helps ensure evaluation is part of implementation planning. It creates a visual map of the connections between the activities undertaken and the outcomes sought. It also deliberately looks for the lessons to be learned, promotes better understanding of strategies, what social impact they have had and whether they can usefully be repeated in other settings.

Additional outcome measurement models utilised in different sectors are included in the Templates and Tools section of this manual. Selection of the best model for your agency will depend upon further examination of each model's applicability. Likely considerations include the size and type of organisation and the objectives of measurement. In selecting a tool, agencies might also consider the following:

- For what purpose do we want the information?
- What do we measure?
- How do we measure it?
- What are we going to do with the information?

## CELEBRATE PERSISTENTLY

In addition to formal monitoring and evaluation, make sure you are generating short term wins and celebrate them. This is not glib advice. Maintaining motivation is critical to achieving, accelerating and sustaining change.

Wins accumulate over time and lead to tangible results including changed behaviours. To ensure they are sustained over time it is important to define and communicate how they are contributing to the organisation's success. What better way to do this than by celebrating?

Celebrating the connections between the changes you have made and the improved capacity you have created are critical to winning over hearts as well as minds. (Kotter 2015). And of course when you have a big win, why not have a big celebration?

## SUPPORT MATERIAL

### Suggested Readings/reference materials:

- » Australian Research Alliance for Children and Youth & KPMG (2009) *Measuring the Outcomes of Community Organisations*
- » Homeground Services (2011) *Measurement of Client Outcomes in Homelessness Services* (literature review)
- » Department of Health and Human Services (2013) *Understanding Program Logic*. [Access it here](#)
- » Julia Coffman (1999) *Learning from Logic Models: An Example of a Family/School Partnership Program* published free on line 2015 Presidents and Fellows of Harvard College [Access it here](#)

## TOOLS

- » Templates and Tools No: 10 Outcome measurement tools.

## HELPFUL TIPS

- » To maintain motivation communication is necessary throughout the entire change process.
- » Remove any barriers.
- » Monitor your progress to identify early any unforeseen problems.
- » Measuring outcomes will allow you to know to what extent you are making a difference in your consumers' lives.
- » Evaluate your progress by re-instigating the audit tool you used previously.
- » **Celebrate your wins!**

# CHAPTER 11 - TEMPLATES AND TOOLS

## NO 1: RESISTANCE ASSESSMENT SURVEY

Below is a list of potential areas for resistance that you may be experiencing in the implementation of the project. For each area indicate the degree to which you agree or disagree by placing your response in the Rating column from the following scale.

1. Strongly disagree      2. Disagree      3. Neither agree or disagree      4. Agree      5. Strongly agree

Assess the scores individually and highlight any scores that are greater than 3. This area should then become your primary focus for addressing the greatest resistance to your project.

Areas of Resistance	Description	Rating
Lack of understanding of the purpose and drivers of the changes	There may be a lack of understanding of the purpose of the project. There may be a lack of awareness of the need for the change to occur.	
Feeling of losing control	People support what they have helped to create. If they feel they have not had sufficient input, resistance usually increases.	
Lack of support from various levels in the organisation	If people perceive that key individuals or groups in their area are not genuinely supportive of the project, their acceptance is difficult to secure.	
Feeling that there is a real threat to existing power, job security or personal and career goals	Resistance is increased if people believe the change will result in greater emotional or career costs relative to what they may gain.	
Concerns about a lack of skills and knowledge	People may resist change if they believe they do not possess the skills or the ability for optimal performance during and after the change.	
High level of impact on daily work patterns	Failure to acknowledge and, if possible, minimise the impact of project team activities and changes on people's work patterns tends to promote distrust and alienation.	
Lack of time to absorb the changes	The ability of staff to assimilate the change and all its consequences must be assessed.	
High level of uncertainty	Sometimes just the uncertainty of the situation can make people react negatively.	
Adverse changes to key working relationships	People may be resistant if they feel the changes may adversely affect the way they relate to others or who they work with or report to.	
High level of past resentments and dislikes	People may distrust or dislike sponsors or change agents or have had negative experiences around change – if this is the case, a lack of acceptance and enthusiasm for the change will quickly materialise.	
Lack of incentives and rewards	Change involves learning and learning usually involves errors. When people are not given the freedom to make mistakes while learning, they become afraid. People need to be rewarded for accomplishing the change in the form of something they truly value.	

Adapted from: Queensland Government (2008); Change Management Plan: Workbook and Template

## NO 2: TRAINING NEEDS ANALYSIS TEMPLATE

*Complex Needs Capable: A Practice Resource for Drug and Alcohol Services* was developed as part of the Network of Alcohol and Drug Agencies (NADA) Practice Enhancement Program (PEP) in 2013. Further information relating to the tool can be found [here](#).

This tool was originally developed for use in the alcohol and other drug sector, however it can be easily amended and adapted for all other sectors.

### TRAINING NEEDS ANALYSIS

This survey has been designed as a guide for drug and alcohol organisations wishing to review their staff training needs. Questions and multiple choice answers should be deleted, added or amended as necessary to reflect your service.

#### Why is the survey being done?

This survey is designed to give [insert service name] an overview of staff experience and formal education/training. The survey then identifies staff need in terms of training/resources. This information can be used in conjunction with funding requirements to design a training calendar to meet staff, manager and organisational needs.

#### How long will it take to complete?

It should take between 15 - 20 minutes to complete. [Insert service name] acknowledge time limitations that staff are working under and have made this form as easy to complete as possible. Please remember the feedback you provide will lead to the training options available to you.

#### When does it need to be completed by?

The survey is to be completed in the next seven days. [Insert specific date and time if preferred].

#### How is the survey to be completed?

[Insert method of completion] [Options include manual completion and collation or online survey functions (e.g. survey monkey). Services should consider workers anonymity, time and resources when choosing survey method.]

#### What will be done with the survey results?

The results will be compiled and summarised. This summary will be used to identify key training needs within [insert service / program(s) name(s)]. These needs will be matched against funding requirements where applicable. Once priority areas have been identified these will be matched to existing training options or may require the development of specialist training.

#### How will the findings be communicated?

The survey results will be placed [insert location e.g. intranet] and staff will be emailed when this occurs. Managers will be provided a summary of findings and encourage to discuss the results with staff. The results may also be used in conference presentations or research based publications. [Delete / amend as required].

## A. DEMOGRAPHICS AND CURRENT ROLE

### 1. Which program/s do you work for? [Delete if not applicable]

<Insert list of programs within your service>

### 2. Gender

Male  Female

### 3. Age

18-25  26-30  31-35  
 36-40  41-51  46-50  
 51-55  56-60  61 or over

**4. Which of the following describes your current professional title? [Amend options as necessary]**

- Drug and alcohol worker
- Social worker
- Psychologist
- Administrator
- Other ( please specify)
- 

**5. Which category describes your current position within [insert service name]?****5.a. [Amend as required]**

- |   |  |
|---|--|
| <input type="checkbox"/> Manager                  | <input type="checkbox"/> Service Coordinator       |
| <input type="checkbox"/> Administrator            | <input type="checkbox"/> Team Leader               |
| <input type="checkbox"/> Outreach Worker          | <input type="checkbox"/> Community Services Worker |
| <input type="checkbox"/> Student                  | <input type="checkbox"/> Volunteer                 |
| <input type="checkbox"/> Maintenance and services | <input type="checkbox"/> Family Support            |

**5.b.**

- Full time       Part time       Casual

**6. How long have you been working / volunteering in the drug and alcohol sector?**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 1-2 years   | <input type="checkbox"/> 3-4 years        |
| <input type="checkbox"/> 5-6 years          | <input type="checkbox"/> 7-8 years   | <input type="checkbox"/> 9-10 years       |
| <input type="checkbox"/> 11-15 years        | <input type="checkbox"/> 16-20 years | <input type="checkbox"/> 21 years or more |

**7. How long have you been working / volunteering for [insert service name]?**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 1-2 years   | <input type="checkbox"/> 3-4 years        |
| <input type="checkbox"/> 5-6 years          | <input type="checkbox"/> 7-8 years   | <input type="checkbox"/> 9-10 years       |
| <input type="checkbox"/> 11-15 years        | <input type="checkbox"/> 16-20 years | <input type="checkbox"/> 21 years or more |

**8. Have you ever worked in a related sector e.g. mental health, disability?**

- Yes (if yes complete 8a)       No (if no proceed to 9)

**8. a How long for?**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 1-2 years   | <input type="checkbox"/> 3-4 years        |
| <input type="checkbox"/> 5-6 years          | <input type="checkbox"/> 7-8 years   | <input type="checkbox"/> 9-10 years       |
| <input type="checkbox"/> 11-15 years        | <input type="checkbox"/> 16-20 years | <input type="checkbox"/> 21 years or more |

**8. b. If yes what related sector?**

- Mental Health       Criminal Justice
- Homelessness       Child Protection
- Disability
- Other (please specify)
-

**8. c. Did you specialise within the above indicated sectors? E.g. working with people with personality spectrum disorders within mental health.**

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**9. How many hours (approximate) per week are you employed / or volunteer in your current role?**

- 7- 5                       16-25  
 26-30                    31 +

**10. Which shift type do you most commonly complete? [Amend as required]**

- Day Shift                     Night Shift  
 Weekend                     Combination

**11. What do you find most challenging about working with the client group accessing [insert service name]?**

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**12. What do you enjoy most about working with the client group accessing [insert service name]?**

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## B. EDUCATION AND TRAINING

**1. a. Please tick all the education levels you have completed.**

- School Certificate / Intermediate Certificate (or equivalent)  
 HSC/Leaving Certificate (or equivalent)  
 TAFE Certificate/s (or equivalent) – Please specify below.  
 TAFE Diploma/s (or equivalent) – Please specify below.  
 Undergraduate Degree/s - Please specify below.  
 Postgraduate Degree/s - Please specify below.

**1.b. Completed Courses (Please specify details of any course indicated in 1.a)**

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**2. Please specify training/education that you are currently enrolled in:**

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**3. Please specify any formal education related to your current employment that you would like to undertake / are considering undertaking.**

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you are planning to engage in further study related to your current employment, how could [insert organisation name] support you?

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**C. TRAINING PRIORITIES**

[Insert service name] works with clients who present with a wide range of multiple and complex needs in addition to their drug and alcohol misuse problems. [Identify here if specific funding has been targeted at specific training needs / areas]

**1. Below is a list of different training topics that may be developed into a training calendar for staff. All training topics will be designed to increase staff capacity to support clients already accessing our service.**

**If you are involved in client treatment please identify what you believe are priority areas. If you are not involved in client treatment please proceed to question C.4.**

	Low Priority	Moderate Priority	High Priority
[insert list of training topics to be considered examples laid out below]			
Signs of withdrawal and intoxicification			
Understanding mental illness - depression			
Supporting clients involved in the criminal justice system			
Supporting clients with a cognitive impairment (including alcohol related brain injury)			
Supporting clients from a CALD background			
Supporting clients who identify as Aboriginal			

**2. Where in-house training is tailored or when training is designed specifically for [insert service name] there is capacity to influence the training content. For those training topics identified as high or moderate priority please expand on what content you would like included in these training topics.**

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**3. For those training topics indicated as low priority, please identify why you feel this is the case. E.g. Already highly skilled in this area; client numbers don't reflect this need.**

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**4. Please identify any additional training topics that you would like to access. Please identify a few points relating to what you want the training to cover.**

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**5. Is there any training you have attended that was helpful in your work at [insert service name] that you think would be of benefit to your colleagues?**

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Thank you for your time.

### NO 3: STAKEHOLDER ANALYSIS TOOL

Name of individual or group	Need for support	Likelihood of support

**In the first column, list all the major individuals and groups that need to go along with this idea.**

**In the second column, rate the level of support you need from each individual or group on a scale of 1 to 5.**

5 = They must take an active part in the development and be vocal champions for the change.

4 = They must take part in the development.

3 = They need to go along with whatever is decided.

2 = It's OK if they have some objections.

1 = It's OK if they resist strongly.

**In the third column, list the level of support you can expect from them today.**

5 = They will fully support and champion the change.

4 = They'll help some.

3 = They'll go along with whatever is decided.

2 = They are likely to complain.

1 = They are likely to resist this change openly and strongly.

**Examine the scores. For effective change, you need matching scores such as 5/5, 4/4 and 3/3. These scores indicate that the support you need matches the support you are likely to receive. Mismatches are dangerous, especially 5/1, 5/2, 4/1, 4/2. All of these indicate that you need strong support but you are likely to get resistance. This tells you that these relationships need work.**

Adapted from: Queensland Government (2008); Change Management Plan: Workbook and Template

## NO 4: AGENCY AUDIT TOOLS

There are a range of agency audit tools, most of which are too lengthy to include as an attachment to this document.

The following is a list of audit tools that can be used by organisations across different sectors and amended/adapted where required. Some of these tools cover agency wide domains, and others are audit tools for specific clinical programs:

- » Wachira, E., M., *Organizational Capacity Audit Tool* GeSCI (n.d.) [Access it here](#)
- » *McKinsey and Company Organizational Capacity Assessment Tool (OCAT)* (n.d.) McKinsey on Society Web Portal. [Access it here](#)
- » *Take Your Temperature: A Brief Organisational Health Check Clinks* (2013) [Access it here](#)
- » COMPASS™ (Comorbidity Program Audit and Self-Survey for Behavioral Health Services) is a tool that can be used by services to assess program competencies in multiple areas that reflect standards for Dual Diagnosis Capable mental health and AOD services. This tool was developed to assist in the implementation of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model for systems change (Minkoff, 2001) The suite of tools includes:
  - COMPASS – EZTM – designed to help programs consistently undertake self-assessment at regular intervals
  - CODECAT – EZTM - is a tool for clinicians to evaluate their own attitudes/values/knowledge and skills working on development of their recovery-oriented complexity competency. It can also be used by supervisors to identify where clinicians might need more support or training.
  - The tools are available at the Zia Partners website ([www.ziapartners.com](http://www.ziapartners.com))
- » *Dual Diagnosis in Capability in Addiction Treatment (DDCAT) Index Toolkit* Adapted for use by the Department of Health and Ageing (2008) is an instrument that can be used for measuring capacity of an AOD service to provide dual diagnosis services. The DDCAT evaluates 35 (33 in the Australian context) program elements that are subdivided into 6 dimensions:
  - Program Structure
  - Program Milieu
  - Clinical Process dimensions (Assessment and Treatment)
  - Continuity of Care
  - Staffing
  - Training
- » The Agency Dual Diagnosis Capability Checklist, developed in Australia by Gary Croton is one of a suite of checklists available through the Dual Diagnosis Australia and New Zealand website. This checklist covers several domains of an organisation's ability to provide services to clients with a dual diagnosis.
- » A baseline audit is a quality activity that will provide you with:
  - Evidence and an argument for the need to build capacity
  - Pre-capability measures providing a base for growth as you implement your plan
  - Identified strengths and weaknesses that will help define the priority areas to focus on within the plan.

## NO 5: PLAN TEMPLATE

Priority One			
Goal	Strategy	Responsibility	Timeline
1.1			
1.2			
1.3			

Reproduced with permission from Positive Directions, consultancy and training, 2009.

## NO 6: PDSA CYCLES AND TOOL

### PDSA STANDS FOR PLAN – DO – STUDY – ACT

The PDSA is a proven tool that you can use to address just about any process that needs to be implemented or changed. While it appears deceptively simple, it is actually very powerful. The more you use it, the more you improve.

The PDSA cycle was developed by W. Edwards Deming, a statistician and manufacturing consultant in the mid 20th century.

### THE PDSA CYCLE

#### 1. Plan

Plan what you want to happen or to achieve. First set the objectives – decide on the end results you want. Then plan the tasks or activities required to get there.

#### 2. Do

Implement the plan. Do what you have set out to do.

#### 3. Study

Once you have implemented the plan (or a component of it), you then study the outcome. Look at what happened.

- Did you get the results you planned for, expected or wanted?
- Did you get a different result? Was the result you got unwanted or unexpected?
- If it didn't go as planned, why not?
- Are things better now or worse?
- If better, can they be improved? If worse, why and what should you do next?
- Do you need to do something different, continue for longer or change some aspects?

Some methods you might use in this phase include observation, monitoring, measuring, studying the data you collect, analysing, discussing, holding 'management reviews' and looking at results of audits.

**Note:** This phase is also known as 'Check' or sometimes 'Review'. It was originally called 'Check', but Deming renamed it 'Study' later on. He was reportedly concerned that it may be seen to be merely a matter of inspection, whereas it should be far more than that. In this manual, we use 'Study' to give a more accurate clue to the activities that are (or should be) involved.

#### 4. Act

This is where you take action, based on the results and the lessons learned

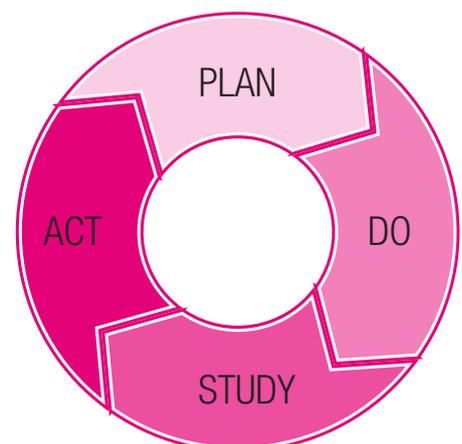
- If the change was a good one, build it into your system.
- If it didn't work out well or needs further work, you might refine it or start again from the beginning, planning some different action.
- Which takes you back to the next stage: Step 1 (Plan) again, but this time with new information and knowledge.

### PDSA AND QUALITY ASSURANCE

The PDSA cycle is designed to be used as part of a continuous quality improvement system. Each time you complete it, you learn new information and knowledge that can be used to improve your change management process.

Thus, you repeat Step 2 (Do) again, with new information and knowledge. And you repeat another cycle of Plan – Do – Study – Act ... followed by another ... and another ... and so on. With each cycle, you cannot help but improve your quality system. Figure 1 shows this cycle.

Figure 1: Plan – Do – Study – Act cycle



**CYCLE: What are the dates of your project?**

**PROJECT: What are you testing?**

**TEAM: Who is conducting the test?**

**BACKGROUND: Who are you testing the change on? What do you predict will happen?**

<p><b>STEP 1: PLAN</b></p> <p><b>PLAN THE TEST</b></p>	What is the objective of this improvement cycle?
	What is the goal? (include a numeric goal to achieve)
	What is your plan to achieve the goal?
	What data sources are needed for the test?
	What measures are used to analyse if you are achieving the goal?
	How often will you monitor this project?
<p><b>STEP 2: DO</b></p> <p><b>TRY OUT THE TEST ON A SMALL SCALE</b></p>	Implement the plan. Document problems and unexpected observations.
<p><b>STEP 3: STUDY</b></p> <p><b>SET ASIDE TIME TO ANALYSE THE DATA AND STUDY THE RESULTS</b></p>	Analyse the results and compare the results with your goal.
<p><b>STEP 4: ACT</b></p> <p><b>DETERMINE IF THE TEST WAS SUCCESSFUL OR THE PLAN NEEDS TO BE REVISED</b></p>	<p>If the test was successful, how will you implement the plan on a wider scale?</p> <p>If it was not successful, what needs to be changed (based on what you have learned)? Should you continue to search for other root causes?</p>

## GUIDELINES FOR USING THE PDSA PROCESS TO CREATE CHANGE

PROCESS	Answer these questions	Generate ideas	Gain consensus	What to do before proceeding to the next step
<b>PLAN</b> Identify an opportunity and plan for change.	How can we get to where we want to be? What do we do first? What's the best way to do it?	May include ideas on: <ul style="list-style-type: none"> <li>• How to solve the problem</li> <li>• How to implement solutions</li> <li>• How to monitor and evaluate the trial improvement.</li> </ul>	Agree on a design and implementation plan for a trial improvement Agree on criteria for evaluating trial.	Brainstorm possible improvements; analyse strengths and weaknesses; establish criteria for selection; establish timelines and a plan for monitoring and evaluating the trial.
<b>DO</b> Implement the change on a small scale.				Document problems and unexpected observations.
<b>STUDY</b> Use data to analyse the results of the change and determine whether it made a difference.	Have we implemented the trial improvement correctly? Have we followed the monitoring plan? Are we improving? What are we learning?		Agree on effectiveness of trial.	Evaluate improvement trial using established criteria; compare results with desired state; check for new problems; decide to implement change system-wide or return to root cause analysis to search for other sources of variation.
<b>ACT</b> If the change was successful, implement the plan and continuously monitor results. If the change did not work, start the process again.	Should we implement system-wide change? Does management support the change? If not, should we continue to search for other root causes?	Develop ideas for planning system-wide change. (Implement action based on what you learned in the study step. If the change did not work, go through the process again with a different plan, using what you have learned in the study step.)	Agree to a new plan for system-wide change. Agree to return to root cause analysis and start the process again.	Prepare to report results of the project; communicate results throughout the organisation; continue to monitor.

Adapted from: Bendigo Community Health

## NO 7: ACTION PLAN

	<b>Actions</b>	<b>Responsible Person</b>	<b>Timeframe</b>
Stakeholder activities			
Project management team activities			
Communication activities			
Training activities			
Audit activities			

Adapted from: Queensland Government (2008); Change Management Plan: Workbook and Template

**NO 8: COMMUNICATION PLAN**

Name of contact person for all project communication: \_\_\_\_\_

Audience	Sender	Key messages	Delivery method	Date	Length of session (if applicable)	Location
Example: Team leaders Senior managers	Example: Project manager					
Example: Staff users	Example: Supervisor					

Adapted from: Queensland Government (2008); Change Management Plan: Workbook and Template

## NO 9: FRAMEWORK CHECKLIST FOR IMPLEMENTING CHANGE AND/OR PROJECTS

### FRAMEWORK CHECKLIST FOR IMPLEMENTING CHANGE and/or PROJECTS:

The following checklist is a useful 'ready reckoner' for project managers, change agents or teams. You can use it to reflect on the activities and stages that you will need to implement. Check your progress on what you have completed, had approved and communicated to key stakeholders. You may also wish to add the dates that each step had been 'ticked off'.

<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Project Title: A brief title for the project, i.e: a few words</b>
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Project Definition / Vision:</b> Elaboration of the title – eg: one sentence. Note: If a strategic project is actually better regarded as a closely related set of (sub-) projects, the project definition should make this clear.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Problem being addressed:</b> A description of the problem(s) or issue(s) being addressed by the project, and how these problems/issues relate to the organisations objectives. Conduct Agency Pre-Audit measure (ie: DDCAT / COMPASS / CHECKLIST)
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Objectives:</b> A succinct statement of the project's aims. A project may have multiple objectives.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Outcomes:</b> A description of the project's expected outcomes: i.e. what it will deliver and what will be different when the project (or change) is completed.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Scope:</b> a description of the boundaries of the project; i.e. what is included (and, if relevant, what is not).
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Business Case:</b> A succinct statement of the expected costs and benefits of the project
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Resources:</b> A description of the resources required for the project and their source. This should identify any resource gaps (e.g. lack of appropriate skills)
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Benefits:</b> Benefits should be categorised as realisable (e.g. cash savings), quantifiable (e.g. where resource savings can be identified but not realised) or tangible (e.g. improved quality). This should include any measures required to ensure that the benefits are in fact realised.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Risks/barriers:</b> The major risks faced by, or barriers confronting, the project and brief strategies for managing them.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>People:</b> A description of: <ul style="list-style-type: none"> <li>» Key stakeholders and their roles.</li> <li>» Consumer and Family/significant other/carer engagement</li> <li>» The beneficiaries (who are we doing this for)</li> <li>» The expected staff impacts</li> </ul>
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Project Plan:</b> An overview of how the project will be managed

<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Strategies / activities:</b> a schedule of the strategies and/or major activities required to complete the project, together with their planned timeframes. A Gantt chart may be useful to use for this.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Responsibilities:</b> Who is responsible and accountable, and for what?
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Consultation:</b> A description of the consultation which has already occurred and will occur in the future, and the major consultation strategies, including consumer and family/significant other/carer consultation.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Communication:</b> A brief overview of the strategies, which will be used to communicate information and updates about the project, its implementation and progress.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Training:</b> a description of any training required as a result of the project or change outcomes (based on the pre audit / baseline)
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Related projects:</b> A list or description of other projects that link / compete / work complimentary to this project.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Critical success factors:</b> What are the factors, which are critical to the success of the project, and therefore of which the sponsor needs to be aware.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Policy / legislative context and influences:</b> A description or list of the affected or related policies and legislation and any change implications.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Quality assurance:</b> A description of any quality mechanisms associated with the project.
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Agency endorsement:</b> A description of how will this be endorsed ie: via a protocol / MoU?  Who will endorse this? CEOs/ Key Stakeholders / Managers  How will this endorsement be communicated to staff?
<input type="checkbox"/> Completed <input type="checkbox"/> Approved <input type="checkbox"/> Communicated	<b>Evaluation:</b> What evaluation strategies will apply to the project  Conduct Agency Post-Audit measure (ie: DDCAT / COMPASS / CHECKLIST) and compare with pre-audit conducted in point 2.1.

Adapted from: Queensland Health, Managing organisational change: a 'how to' guide.

## NO 10: OUTCOME MEASUREMENT TOOLS

There are a range of tools that are designed for use in different sectors. The following is a short list to give you a start, and there are many more tools available.

Examples of validated outcome measurement tools include the Scott Miller tools, the Outcome Star and the Health of the Nation Outcome Scales HoNOS.

- » HoNOS has been used extensively across mental health services in Victoria, and measures 12 specific items/domains. Whilst it focuses on mental health and wellbeing, one of the domains is a measure of problematic alcohol and drug use. Further information relating to the tool can be found [here](#)
- » The Outcome Star can be applied across a range of sectors (mental health, AOD, homelessness and young people) and was designed as a measure for clients in relation to self-reliance and other goals. The domains for each version have been based on a 'ladder of change' which assesses clients' progress towards independence – from 'stuck' through to 'self-reliance'. Further information is available [here](#)
- » The Scott Miller suite of tools include the Outcome Rating Scale, and the Session Rating Scale. The Outcome Rating Scale is designed for clinicians to assess change in their clients across 4 general domains relating to wellbeing, and the Session Rating Scale is for clients to evaluate their sessions with the clinician. These tools are available [here](#)

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