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Care planning sub-program: exit interview report

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Abstract

Background The Centre for Health Service Development (CHSD) was appointed as the National Evaluation Team (NET) to undertake a formative and summative evaluation of the Care Planning Sub- Program of the Local Palliative Care Grants Program (LPCGP). The Care Planning Evaluation Framework developed by CHSD included tools for examining sustainability, capacity building, generalisability, dissemination of lessons and system level impacts and outcomes of the projects. Thoroughly investigating these areas of change as a result of the efforts of the projects is an important undertaking as it touches on some of the main aims of any reform process: effectively building communities of practice; improving the different levels of continuity; and avoiding the threats to local integration inherent in short-term pilot projects. To bring these issues into focus and to draw out lessons for subsequent rounds of the Program, the evaluation framework included exit interviews with each of the 33 project officers at the conclusion of their project.

Keywords

report, interview, care, exit, planning, program, sub

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Care Planning Sub-Program: Exit Interview Report

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1 Background

The Centre for Health Service Development (CHSD) was appointed as the National Evaluation Team (NET) to undertake a formative and summative evaluation of the Care Planning Sub-Program of the Local Palliative Care Grants Program (LPCGP). The Care Planning Evaluation Framework developed by CHSD included tools for examining sustainability, capacity building, generalisability, dissemination of lessons and system level impacts and outcomes of the projects. Thoroughly investigating these areas of change as a result of the efforts of the projects is an important undertaking as it touches on some of the main aims of any reform process: effectively building communities of practice¹; improving the different levels of continuity²; and avoiding the threats to local integration inherent in short-term pilot projects³.

To bring these issues into focus and to draw out lessons for subsequent rounds of the Program, the evaluation framework included exit interviews with each of the 33 project officers at the conclusion of their project.

2 Exit Interview Aim

The aim of the exit interviews was to investigate the projects' perspectives on what their projects achieved at the local level and any themes relating to local palliative care service provision, the methods and tools for care planning and the key lessons that emerged for them as a result of their involvement in the sub-program.

3 Method

All projects were advised of the intent to conduct exit interviews during presentations on the evaluation framework at the National Care Planning Workshops. As each project drew to a close, project officers were contacted by the NET to organise a time to conduct the exit interview.

A semi-structured interview format was designed to collect information about project and program issues and processes. The interview template covered issues relating to any benefits gained from the project, the difficulties they faced, the quality of the resources and support available, project evaluation issues, the role of national workshops and any aspects of the project that could be sustained, generalised or used to build capacity within the palliative care sector (see Appendix 2).

A refinement of the interview template occurred in mid 2008, and formed the basis for the majority of the subsequent interviews (see Appendix 1). This included a number of additional questions relating to the program objectives (question 1.1), key themes (1.4), reporting processes (5), program activities (6), dissemination (8) and lessons and skills learned (9).

In addition, the 'Sustainability, capacity building and generalisability issues' tool (also known as the 'sustainability and spread' tool) was administered (see Appendix 3). This tool covered similar areas of interest to the exit interviews and was a more 'quantitative' approach in the sense of coding and scoring the answers to a set of standardised questions. This was the second time the tool had been administered during the life of each project; the first administration was during the initial site visit to capture expectations from project officers about these issues, and this latter administration was to ascertain whether these expectations had been met.

¹ Iedema R, Meyerkort S and White L (2005) *Emergent modes of work and communities of practice*. *Health Services Management Research*, Vol. 18, No. 1, pp. 13-24.

² Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE and McKendry R (2003) *Continuity of care: a multidisciplinary review*. *British Medical Journal*, Vol. 327, pp. 1219-1221.

³ Kuipers P, Humphreys J, Wakerman J, Wells R, Jones J and Entwistle P (2008) *Collaborative review of pilot projects to inform policy: a methodological remedy for pilotitis?* *Implementation Science*, Vol. 5: 17.

The interview questions, with a blank copy of the sustainability and spread tool plus the initially completed tool, were sent to the participants prior the interview.

The interviews were not recorded. The interviewers transcribed during the interview, and then these notes were refined within 24 hours of conducting the interview. The transcribed interview was then sent to the participant for review to ensure accuracy of content and interpretation. Consequently, the quotes presented in this report are participants' paraphrased comments taken directly from the interview transcripts and are not verbatim quotes.

For each question, the interview responses were copied into an Excel spreadsheet. These responses were reviewed and coded into themes by either one of two researchers. The coding systems were checked by a third researcher and consistency was achieved for the purposes of inter-rater reliability.

4 Results

A total of 33 interviews were conducted, 29 over the telephone and four interviews were conducted face-to-face to coincide with a site visit or the third national workshop. The first two interviews were conducted in July and August 2007 respectively, five were conducted during 2008 and the remainder (26) conducted in March and April 2009. Ten exit interviews were conducted by the relevant NET staff member allocated to each project for the duration of the sub-program, and 23 of the latter interviews were conducted by a fourth NET member, who was involved in the program during the early stage and rejoined towards the end of the program. Having this additional NET member conduct these interviews was seen as an expedient approach, as well as being advantageous as it brought a measure of independence to the process.

All interview participants included the project officer, except for one which was held with the project manager, as the project officer had left the organisation. Twenty-nine interviews include just one participant and four interviews had two or more participants.

As noted above, the first seven interviews conducted in 2007 and 2008 used some interview questions that were phrased differently to those used later than mid-2008. These interviews were predominantly conducted in person, at a mutually convenient (and often opportunistic) time suitable to both parties. The remaining 26 projects all received the refined interview template, mostly conducted by telephone at a mutually convenient time. In some of the latter interviews, questions 7.1, 7.2, 7.3 were not asked due to time restrictions as it was felt that responses to these questions were covered in the *sustainability and spread* tool. In eleven interviews the *sustainability and spread* tool was not administered during the interview, and in total 31 projects completed and returned the tool.

The duration of interviews ranged from 45 minutes to 150 minutes, with the average interview length being 88 minutes. The duration was partly dependent on the succinctness of participants' responses. The considerable length of many interviews is possibly due to the fact that projects were actually 'exiting' and this interview was part of a 'debriefing' and/or 'closure' process.

Responses to questions were normally entered into a template during the interview, subsequently refined within 24 hours (in the majority of cases) and sent to the participant for review to ensure accuracy of content and interpretation. Eleven participants chose to recommend amendments.

The following sections 6 to 14 of this report outline the key findings to each of the questions asked in the exit interviews, followed by a discussion, conclusion and any recommendations arising from the interview findings. As this report is essentially about qualitative interview findings, the results from analysing the *'sustainability and spread'* tool are not discussed in detail in this report, and can be found in 'Care Planning Sub-Program: findings from the national evaluation'.

5 Program objectives

The exit interview template commenced with a series of 'scene-setting' questions relating the project to the overall program objectives and the key themes articulated in the sub-program guidelines, which were broadly articulated to improve the use of care planning to support clients to remain living at home during end-of-life care.

Overall, the projects reported that they had achieved the program objectives and addressed the key themes, and in most cases attained more than they had originally planned. Details regarding the projects' results and discussion of the program objectives and key themes are not covered in this report, and can be found in 'Care Planning Sub-Program: findings from the national evaluation'.

6 Project activities

The set of questions covered in this section focus on the impact of the project activities that were undertaken. These questions were included to capture similarities and differences between the projects and to provide a way to synthesise the achievements and summarise any lessons from across the range of projects.

6.1 What did your project gain?

Participants were asked to consider what their organisation gained from its involvement in the Care Planning Sub-Program. The main gains identified from 32 projects were as follows:

- Development of palliative care skills for staff
- Development and/or enhancement of partnerships between organisations
- Increased awareness of palliative care
- Development of resources
- Improvement of the organisation's profile regarding palliative care
- Improvement of patient outcomes
- Improvement of the organisation's capacity to carry out research

Over half of the projects identified an increased level of palliative care skills for staff. This is perhaps unsurprising when considering the heavy focus upon education of many of the projects. Given the large number of projects which targeted the residential aged care sector, the increased skill level was particularly apparent, as highlighted by the following two quotes:

"The residential aged care facility (RACF) staff have gained skills, knowledge and confidence in caring for patients with palliative care needs".

"Through education, the capacity and capability of care staff was increased, which had the unexpected outcome of improving the attraction and retention rates of staff working in the facilities. Unusually for this sector, the RACFs involved did not experience any staffing problems and agency nursing staff did not have to be recruited in the time since the project commenced".

About a third of the projects reported that there has been development and/or enhancement of partnerships at the organisational level. For many participating organisations the sub-program provided an opportunity to collaborate for the first time with key stakeholders.

"(the hospital) and the RACF partners gained a close partnership that built trust, collaboration and an effective working relationship".

"The project enhanced collaboration between local stakeholders (particularly GPs) and provided them with resources that will be available on an ongoing basis".

Participation in the Care Planning Sub-program also led to an increased level of palliative care awareness from the organisation's perspective.

“The project has reinforced the organisation’s credentials as a leader in palliative care with local service providers and the local and wider community”.

“The project has raised the profile of palliative care within General Practice”.

“The organisation’s knowledge and understanding of palliative care increased. This was across all areas and included the quality and health promotion units and also at executive level, primary and specialist services and in the community”.

When answering this question, a number of projects commented on the fact that getting the funding for the project was a gain for the organisation. As one project expressed it:

“The program gave us the time and money to do things we had been considering for some time, to develop the protocols and address gaps we had already identified”.

The three other themes that emerged in the context of discussing gains related to improving the organisation’s profile, improving patient outcomes and improving the organisation’s capacity to carry out research.

6.2 What did your project learn?

Participants were asked to consider what their organisation learned from its involvement in the Care Planning Sub-Program. All 33 projects gave examples of organisational “learnings” and the main ones were:

- Difficulty in engaging general practitioners
- Importance of collaboration and partnerships
- Understanding and working with the aged care sector
- Resistance to training from some health service staff
- Importance of using ‘champions’ (such as link nurses, clinical champions)
- Importance of using change management strategies
- Requirement for project officers to have project management training

Some projects found that it was difficult to engage GPs into their project activities such as case conferences or education sessions. Two projects mentioned that they tried using the Enhanced Primary Care (EPC) items as a way to engage GPs, but this proved to be unsuccessful.

“Enhanced Primary Care Medicare items cannot be forced upon an unwilling and under-resourced sector”.

However, one comment related to a potential solution to this issue as follows:

“It is important to have good administrative support for GPs to facilitate their attendance at the multidisciplinary team (MDT) meetings. Working with GPs at these meetings is an incremental process of building their confidence over time. This process has been enhanced by the presence of an enthusiastic GP advocate”.

A number of organisations learned the importance of collaboration and building partnerships. This relates to the previous question, where projects reported that there has been either development and/or enhancement of partnerships at the organisational level.

About a quarter of the projects worked with RACFs and in doing so, were able to understand the challenges and constraints of the aged care sector and were required to address these to implement their activities.

Other lessons that emerged from the projects related to the importance of identifying or using ‘champions’, the importance of developing explicit strategies in change management and the need for project officer training in project management.

6.3 What did your project do best?

Participants were asked to consider what they did best with regards to their involvement in the Care Planning Sub-Program. All 33 projects gave responses to this question, and the five main themes to emerge were:

- Development and/or enhancement of partnerships
- Implementing a consultative approach
- Engaging general practitioners
- Increasing awareness of palliative care
- Development of tools and resources

By far the most common response to this question related to the development of partnerships between the host organisation and other stakeholders. A consistent theme was the importance of ongoing investment in relationships, which involved respecting and building on existing relationships as well as seeking out new relationships important to each project in a collaborative way. An example of the importance of partnerships is highlighted in the following quote:

“Robust relationships were fundamental for this project. The project needed to develop and maintain good relationships, both formal and informal, with a wide range of stakeholders.”

Another closely related theme to building partnerships was the importance of having a consultative approach when working with key stakeholders.

“The project officer used a broad range of resources and information. Information relating to the project was widely disseminated to other key stakeholders for feedback. In this way developing the model was a very collaborative and inclusive process.”

While responses to the previous question highlighted difficulties in engaging GPs, responses here related to positive aspects of GP liaison. Activities involving GPs included: encouraging them to use EPC Medicare items; providing education to empower GPs to provide high-quality palliative care; requesting feedback from GPs via surveys; and facilitating GP participation in multidisciplinary team (MDT) meetings. For example, one respondent felt that their organisation was most successful in building trust between services, and the MDT meetings were the catalyst:

“This resulted in an increase in GP engagement with 92% of all Case Conferences involving the patients’ GP. This compared with 50% in the early days. The MDT meetings have facilitated a system of palliative care rather than a palliative care service. The whole team is engaged, i.e. the hospital, the RACF and the GP. This recognises that palliative care is operating in the domain of primary care.”

The two other themes that emerged related to increasing palliative care awareness and developing tools and resources.

6.4 What (major) difficulties did your project encounter? Were they expected? Were they resolved? If so how?

Participants were asked to consider what major difficulties they encountered whilst working in the Care Planning Sub-Program. All 33 projects shared the difficulties they had encountered and the common difficulties were:

- Liaising with Area Health Services
- Engaging GPs
- Changes in the project officer position
- Over-ambitious project plan
- Ineffective steering committee
- Limited support from senior management
- Inadequate budget
- Delays with ethics approval

A common theme related to the reported difficulty with liaising with local Area Health Services and all of these comments related to projects operating in NSW. The main comments related to the perception that Area Health Services are large insular organisations that are resistant to change. They were also seen to be characterised by poor levels of funding, low morale of staff and a self-perception of overburden. Multiple layers of management were also identified as a barrier to effective change management within Area Health Services. This is reflected by the following:

“The AHS feel that their workload is manic and that any additional tasks take them away from service delivery and thus they are reluctant to get involved. The project activities are seen as extra work.”

Again, the problem of engaging GPs was a common theme. This issue is highlighted in the following comments:

It was hard to get GPs involved. The project lost the GP champion and couldn't find another one. Trying to engage GPs was a real struggle. No one wanted any change. The GPs liked the way it was and the Palliative Care service had given up on GPs (before even trying to change.)”

“GPs were not always interested. It was in many cases difficult to engage with them and as a result the project officer worked more closely with nurse practice managers. The GP engagement was better in some regional areas than others.”

“Engaging GPs was very difficult. GPs were a large focus of the project but as the project moved into RACFs they did not increase the number of GPs providing services to RACF. The project officer found that younger GPs were particularly hard to engage – could be attributed to a greater regard for work/life balance?”

Another difficulty related to the issue of frequent changes of the project officer position. One project reported having three changes of project officer.

In four instances it was reported that the projects aspirations were too ambitious. This is neatly captured by the following quotes:

“The project scope was too big and the budget was too small.”

“The proposal and its original protocol was difficult to operationalise. The time lines and evaluation plan were unrealistic.”

Lack of support from the steering committee and senior management was also an issue. With regards to steering committee participation, the following comment sums up the issues:

“There were problems with relating to stakeholders as a group (steering committee). The committee would turn up for meetings and return feedback but the lag time in getting feedback was far too long.”

Other difficulties encountered related to budgetary issues and delays with ethics approval.

7 Support and resources available to the project

The following set of questions were included to capture whether the funding, timeframe and support provided by key stakeholders was sufficient to successfully achieve the goals and aims of their projects.

7.1 Funding: Was the funding sufficient?

Twenty-six projects thought the funding was sufficient, whilst seven projects felt that it was not adequate.

Three projects felt that their original project plan was too ambitious. Some projects renegotiated their contract with DoHA to reduce the scope of the project plan. Other issues relating to funding included insufficient funding for resources, an underestimation of the costs of developing and implementing project strategies, an inability to invest in embedding sustainability in the project, and no allowance in the budget for wage and price increases e.g. petrol prices.

“The project officer took a pay cut to be able to do the position and ultimately the project officer had to leave the project early as an award pay rise was not built into the original project budget. The project officer felt as though they should have renegotiated the contract with DoHA. The original project plan was too ambitious for the available funding.”

7.2 Time: Was the time frame realistic?

Of the 33 projects, 19 felt that the time frame for their project was not realistic. Of these, five projects indicated that they would have liked more time to bed down issues relating to sustainability, and a further four indicated that more time was needed to influence practice changes.

“Three years was good, the project was coming to a natural end and most of initiatives will stay in place. There is however a lot of documentation that has to be printed at own cost. From a sustainability perspective the project would appreciate additional funding of \$10,000 per year to keep the resources going and cover printing costs.”

7.3 Local support: in-kind/organisational support (including key stakeholders)

All 33 projects said that they received good support from their host organisation and key stakeholders. Organisations that were mentioned as particularly supportive were the local Divisions of General Practice, the projects' steering committees and the local Area Health Service.

Three projects indicated that they did not receive adequate support from the local Area Health Service.

8 Evaluation

From the NETs' perspective evaluation was an integral component of the projects' activities and a question was included to capture the individual evaluation-related experiences of the projects.

The participants were asked to consider how they felt the evaluation component of the project went. All 33 projects commented on their project evaluation, with the common issues being:

- Evaluation not planned or included in the original project application
- Practical issues around the evaluation process
- Usefulness of the project evaluation

A little under a third of the projects did not have dedicated evaluation funding in their budgets, which meant that the evaluation was not planned. One project commented that there was no mention of evaluation in the original tender documentation, which could be a recommendation for future programs. Another suggestion was that the application process should have had a greater emphasis on the importance of evaluation:

“The team felt as though the tendering process was too rushed to consider the evaluation plan properly which turned out to be a month's work in itself. The team felt that perhaps the projects could be funded in a two-step process. The first process would be to develop a project plan and then the second to develop an evaluation plan to support it”.

For those projects that had not thought clearly about evaluation the following quote neatly sums up their experiences:

“The project team was not really prepared for evaluation. There were too many components of the project to evaluate and as a result we have ended up with too much information. Pulling the evaluation data together has been an additional task which was not factored into the original funding application. The team recognise that evaluation is crucial, but it also represents a lot of work. The project activities continue in the background as does the evaluation. The evaluation needs to be realistically funded and timed.”

However, it is important to note that six projects indicated that the evaluation component was considered and budgeted for in the original funding application.

Practical issues associated with the process of evaluation were also highlighted. Some projects needed to develop their own tools as the Centre for Health Service Development (CHSD) tools were not specific enough for their needs. Other projects highlighted a lack of project officer experience in evaluation methods and analysis, poor participant response rates, and too much evaluation data being collected.

On the positive side, projects also commented on the usefulness of the evaluation process and for some projects the evaluation of the project will be ongoing.

“The evaluation was a very useful process. It meant that the project was able to demonstrate why certain goals were not reached. It also provided evidence that assisted in reporting project progress and added credibility.”

A number of projects used external evaluators. One project felt that in hindsight the evaluation should have been externally managed and made the following recommendation:

“The project officer believes that a high quality evaluation should be carried out externally and independently. The project officer is too close to the details of the project and feels that it is difficult to step outside the project to evaluate it. The project officer felt as though DoHA should have set up the evaluation framework before the projects commenced”.

9 Reporting

The following set of questions focused on project reporting. Reporting in six monthly cycles to both DoHA and the NET was an important part of the Care Planning Sub-Program. These questions were asked to ascertain how the projects felt about this process. This was of particular interest to the NET as the two key reporting templates used were new to this program.

9.1 Two reporting templates - Progress Report templates (DoHA and NET ones)

To what degree did you find the two reporting templates useful?

Just over half of the projects indicated that they were happy to complete both, and found the templates user-friendly.

Some common criticisms of the two templates arose, with six projects objecting to the duplication of information between the two templates, and seven projects commenting about the arduous and time-consuming nature of completing both requirements. Technical difficulties such as formatting also proved a challenge for four projects.

It is important to note that three of the projects that were critical of the templates also commented that they could see the value of completing both. For instance, the process made them pause and

refocus on what the project was trying to achieve in six-monthly cycles. It was also commented that completing the progress reports assisted the project officer in the writing of the final report.

How could any of these processes been improved?

Suggestions for improvements were to reduce duplication between the two templates, and to consider merging the two templates into one consolidated format to meet both requirements.

9.2 Final report (using the evaluation report template) including the Final Report guideline document and the support by NET

To what degree did you find the final report template useful?

Twelve projects could not answer this question, as either they had chosen not to use the evaluation report template or they had not commenced working on it yet.

Around half of those who had worked with the template had found it to be useful. Two projects saw its value as a dissemination tool and indicated that they would use the report internally to seek further funding opportunities and to demonstrate successful project outcomes. Another commented that the process and the report itself was a way of encapsulating and validating everything that the project had achieved. For another project, this report will provide the basis for a journal article.

A particularly positive comment was:

“Brilliant! The project officer learned a lot from completing the [final report] template. Glad that this process was part of the project. It gave structure to the report and provided a good template for summarising the research. The NET’s support was excellent. A tool the project officer will use in the future.”

There was uncertainty from three project officers as to whether the evaluation report template was optional or not, with these projects expressing that they required more clarity from both DoHA and the NET on this issue.

The time-consuming nature of completing the report was commented on by six projects. Similarly, project officers were concerned that the report was going to end up being an enormous document, especially once the appendices were attached.

How could any of these processes been improved?

One project stated that a completed example from the NET would have been useful as a model, and another said it would have been useful if the template included standard responses to particular questions as a guide. One project suggested that project officers need to be clearly informed of the time-consuming nature of the task.

The final report format and the details on the requirements were presented at two of the three workshops and in an information bulletin, plus discussed individually with project officers. Some project officers, who have written reports before, were aware of the time factors.

For future programs, the implication is that there should be a requirement for a clear template document to be provided and one that states the potential time frames, for instance, ‘allow six weeks for final report writing’.

10 Program activities

The following set of questions focus upon the Program activities. It is important to point out that the Care Planning Sub Program did far more than just provide each of the 33 projects with a 'bucket' of funding to carry out their activities. Rather the sub-program supported each of the projects with the provision of a member of the NET who supported, advised and nurtured the projects as required.

The NET also provided many different resources to the projects to assist with sub-program communication and project evaluation activities. DoHA officers were also a key component of the sub-program as they provided a mechanism of project support by being readily available to address any questions about the requirements of the projects and the aims of the sub-program.

These questions were asked to ascertain which components of the sub-program were of use to the projects and which components would benefit from being reviewed.

10.1 Site visits

To what degree did you find site visits useful?

All 27 projects who were asked this question found the site visits useful, commonly describing the site visits as supportive, helpful and useful. Three projects specifically noted the benefit of the face-to-face contact, in terms of building a relationship with their NET member and the value of site visits keeping projects on track and focussed.

"They were essential and have provided valuable face to face support. It was great to build a relationship with the NET".

"This was a good process. It was nice to touch base with the NET. It was helpful to be able to have discussions to help 'see the wood and not the trees'. This kept the PO on track."

Ongoing support following site visits, by phone and email, was also noted as particularly useful by many projects.

"Great! Two visits plus numerous informal chats. Helped the PO refocus on what the project is trying to do...Kept me on track!"

"The NET were always accessible and practical in responses."

How could this process have been improved?

Four projects noted the importance of having the first site visit occur very early in the life of the project. However, two project officers felt that this occurred too early, in relation to the newness of the project, which made the process feel overwhelming.

10.2 Annual Workshops

To what degree did you find the Annual Workshops useful?

All 33 projects found the Annual Workshops very useful and the benefits of the most commonly noted were that they:

- Provided a good forum for networking
- Provided a great opportunity to share resources and information
- Provided a forum for finding out what other projects were up to
- Enabled the project officers to feel part of a very supportive team (or program)
- Provided information and support for the project evaluation

- Placed the sub-program in its national context

Four project officers felt 'out of their depth' at the first workshop and found the process a bit intimidating and overwhelming. Six projects felt that the first workshop was less useful than the others. This highlights the varying needs of the project officers, which was acknowledged by NET, and was attempted to be accommodated in the planning of the workshops.

Two projects discussed the value of being able to look at documentation (i.e. PowerPoint presentations on the website) after the workshops.

How could this process have been improved?

One project suggested having an additional workshop after the funding period (as an opportunity to celebrate the success and achievements of the program), however two projects commented that they thought three workshops was enough.

Three projects thought that the process could have been improved by having the first workshop conducted earlier.

10.3 State Forums

To what degree did you find the State Forums useful?

There were five State Forums formed in each of the following states – New South Wales, Victoria, Queensland, South Australian and Western Australia. The majority of projects were supportive of the forums with twenty-two expressing that they had some value. The forums were most commonly described as providing an excellent opportunity to share ideas and network and were seen by some as an essential part of the program.

However common criticisms of the State Forums included that they were a repetition of the Annual Workshops and that grouping projects by geographic area did not necessarily mean they had anything in common with each other. It was also noted by two respondents that the process of organising the forums was burdensome and time-consuming.

Overall, project officers expressed their appreciation of the forums, particularly as opportunities for communication at a state level.

Two states/territories had too few projects to warrant State Forums, and it was felt that their 'exclusion' from this potential source of support led to a greater feeling of isolation.

How could this process have been improved?

Suggestions for improving this process included: providing more direction and leadership to make them a more worthwhile process; providing clearer guidelines for the use of the funding; improving communication (e.g. keeping everyone informed about future meetings); and reimbursing project officers involved in the organisation of the forums.

One respondent noted that,

"This aspect of the program should be built into all future national programs... It offered a great support network."

10.4 List Server

To what degree did you find the List Server useful?

Five projects indicated that the List Server was a great way to share information. Two projects also noted that it created a sense of connectedness to the program, and alleviated feelings of isolation. The List Server was also used as an education and communication tool, and as a way to disseminate more widely the information contained in questions and answers.

Although some projects saw themselves as proactive members of the List Server, others were less proactive. Of the 12 projects that indicated they did not use it, four projects said the reason was the unfamiliarity of the technology (lack of computer skills), and five projects said it was due to a lack of time. Nonetheless, members that did not regularly use the facility found value in just following the discussions, reading comments or responding to relevant questions. Three projects claimed that merely knowing that it existed and was available if needed, was 'comforting' in itself.

Information distributed from DoHA through the list server facility was also seen as important by one project officer.

How could this process have been improved?

No direct suggestions to improve the process were given, but the incidence of project officers not knowing how to use it suggests that there is a training opportunity that should be recognised along with setting up such a facility.

10.5 Information Bulletins

To what degree did you find the Information Bulletins useful?

Nearly all the projects felt that the Information Bulletins were a useful resource, providing concise and practical information. Projects commented that the bulletins kept them on track and made them feel like part of a national program. Two projects said they did not read them due to time constraints, commenting that the health sector is already swamped with too much information.

How could this process have been improved?

One suggestion was that the first bulletin should have been on project management with a focus on how to commence a project, itemising the relevant tasks that need to be done.

10.6 DoHA officers

To what degree did you find the DoHA officers useful?

Projects' responses to this question were overwhelmingly positive with DoHA officers described as interested, approachable, supportive and responsive. Indicative of project officers' responses is the following statement:

"DoHA officers were always supportive and nurturing... I got the feeling that they really wanted the projects to succeed."

It also was noted by ten projects that contract variation and subsequent negotiations were well managed.

How could their roles and/or services been improved?

Two projects stated their confusion about having to report to two groups of people (DoHA and the NET), and suggested that the NET should be a 'one stop shop' for negotiations.

10.7 National Evaluation Team

To what degree did you find the NET useful?

Responses to this question were very positive. All respondents felt that the NET carried out their role particularly well. Members of the NET were described as enthusiastic and encouraging. It is clear that project officers appreciated the involvement of the NET, and the ongoing nature of their support. The following statement reflects the overall sentiment expressed by projects:

“The NET did everything possible to support the projects and were always available.”

How could their roles and/or services been improved?

No suggestions for improving the role of the NET were provided.

10.8 Anyone else

To what degree did you find any one else useful?

Twelve projects did not respond to this question. Of the 21 responses received, organisations that were felt to be particularly useful were: Palliative Care Australia, local Divisions of General Practice and the Palliative Care Outcomes Collaboration. Also, two projects noted that collaboration with project officers from other projects was of particular value.

How could their roles and/or services been improved?

No suggestions for improving the roles and/or other services were provided.

11 Sustainability

The sustainability of the projects was a key component of the Palliative Care Evaluation Framework developed by CHSD⁴, which asks the question, will the Care Planning projects continue to have an impact after the cessation of sub-program funding.

Participants were asked to consider how sustainable elements from the project would be. Nine projects were not asked this question due to time constraints. However, of the 24 projects that addressed this question, 19 indicated that either elements or all of the project activities will be sustained into the future. Of these, four indicated that the model of care developed by the project had been built into the organisations policies and procedures.

Six projects indicated that the sustainability of the project was reliant upon staffing at the organisation level. This situation is highlighted in the following comment:

“The model will continue and the idea of the case conferences and integration. However sustainability does depend upon the staffing of the team. Staffing changes have been challenging and have created extra work for the project officer. You cannot put all the responsibility of the model onto one person’s shoulders and it is crucial to get the whole team involved.”

“Palliative care service will continue to drive case conferencing because...the benefits are known. They know it works and how to do it, but there is a lack of resources and they don’t see it as core business. To sustain it, there needs to be someone who drives it, does the setting up and makes it happen. This needs to be part of someone’s role, e.g., a dot point in practice manager’s job description to ensure the GP attends and is remunerated.”

The issue of funding was also raised as an important indicator of potential sustainability. In one instance the funds generated from selling the project’s resources will enable continuity of their

⁴ Eagar K, Cranny C and Fildes D (2004) *Evaluation and palliative care: a guide to the evaluation of palliative care services and programs*. Centre for Health Service Development, University of Wollongong.

production. In another example the host organisation will continue to use HACC funding to fund one clinician to maintain the project and its activities. In another example sustainability of the project activities have been continued by ongoing funding received from the Rural Palliative Care Program.

12 Capacity building

Capacity building was also a key component of the Palliative Care Evaluation Framework developed by CHSD (see above). The key question here relates to whether or not skills and knowledge have been developed by the projects to support systematic change to service delivery or whatever it was that the project set out to achieve.

Participants were asked to consider how they felt that the project activities had generated capacity. Nine projects were not asked this question due to time constraints. Of the 24 projects that addressed this question, 20 indicated that they felt the project had built capacity within palliative care service delivery or at the organisational level. Training and education sessions have been a particular focus for many of the Care Planning projects and not surprisingly nine projects indicated that capacity had been built by providing health professionals with education sessions. An example of how education can enhance capacity is provided in the following:

“Education and training opportunities addressed the skill gaps in end-of-life care and promoted a palliative approach within the primary RACF workforce. Positive caring outcomes resulting from use of the RAC End-of-Life Care Pathway in conjunction with the on-going education, co-ordinated by the Link Nurse, were progressive and increased over the period of the project. This suggests that the model of networking a Link Nurse, supported by appropriate documents and linked to a specialist palliative care service, provides ongoing increases in the palliative care capacity of generalist staff working in RACFs.”

13 Generalisability

Generalisability was another key component of the Palliative Care Evaluation Framework developed by CHSD (see above). The key question here relates to whether or not the outcomes of the project can be generalised beyond the specific program and project to other settings and circumstances. Participants were asked to consider how generalisable the outcomes of their project were to other settings. Nine projects were not asked this question due to time constraints. Of the 24 projects that addressed this question, 22 stated elements of the model or tools developed by the project could be generalisable to another setting.

However, this confidence regarding generalisability comes with some reservations. One project noted that their advanced care planning Fact Sheet would need altering to be in line with legislation in other States, and another project indicated that their medication imprint system would only be relevant in the State that it was developed due to the jurisdictional issues surrounding medications.

One project indicated that the generalisability of the model of care developed depended very much upon the availability of human resources and a robust information management system to generate key documentation.

However, from a more positive perspective:

“The protocol’s capacity to be generalisable has been a big focus of its design. The project has forged links ... to ensure that there is good communication between key stakeholders. This will also ensure that the protocol is not reinvented by a different organisation. There are plans to embed the protocols across the state. There is also demand and interest for the protocol at a national level ...”

One project indicated that the model of care generated by the project was generalisable outside the palliative care setting:

“The website was showcased at a recent conference in Sydney and feedback suggested that the model could be replicated in other health care disciplines – e.g. disability and different illness types or even in aged care.”

NB. There are other sources of more detailed data on sustainability, capacity building, generalisability (sustainability and spread tool), and dissemination (dissemination log). The results of these tools and additional discussion are available in the 'Care Planning Sub-Program: findings from the national evaluation'.

14 Dissemination

The next questions focus upon dissemination, which is also a key component of the Palliative Care Evaluation Framework developed by CHSD (see above). Dissemination of information is fundamental to both capacity building and generalisability. The key questions here relate to whether or not dissemination was a key part of project planning, and if so, how useful was it and which dissemination activities worked best.

14.1 Did you have a dissemination plan at the outset? Did it change over the course of the project?

Eleven of the 24 projects, who were asked this question, indicated they had no dissemination plan at the outset of their project. One project was unsure if there was a plan because they commenced their role as project officer later. The remaining half of the projects indicated they had some plans for dissemination at the outset. One project stated that dissemination was 'paramount' to their project from the very beginning.

As the projects progressed, it is evident that dissemination plans were established in all projects (or were further developed from their original conception). Five projects noted their realisation of the importance of dissemination as their projects progressed. Ten projects seem to have had plans that were vague or minimal which later evolved to include more improved and expanded activities.

Most commonly, original plans of dissemination included: presentations at conferences, newsletters, staff education, and publishing in journals.

14.2 What activities worked best for your project?

Of the 26 projects who responded to this question, the dissemination activities that worked best were:

- Media activities including newspaper articles and radio
- Conferences
- Newsletters e.g. staff or parish newsletters
- Face to face meetings, where project findings were discussed, usually one to one
- Websites
- Community meetings and presentations within the community

Other activities which worked for either one or two projects were journal articles, tools developed within a project, i.e. GP referral pad, DVD, staff training, consultations with GPs, and the project Final Report.

Outcomes relating to dissemination activities are presented more fully in 'Care Planning Sub-Program: findings from the national evaluation' based on the dissemination log collected by all projects over the life of the program.

15 Concluding Questions

The final three questions were asked of those participants who were interviewed using the second interview template. The focus here is upon the individual project officers who were responsible for the day to day management of the Care Planning projects. The project officers are a key component of the Care Planning Sub-Program and the NET is particularly interested in their individual 'journeys' and whether or not their individual skills and work capacity has been enhanced as a result of their involvement in the Care Planning Sub-Program.

15.1 What lessons will you take away from your experience on this project?

Of the 26 who responded the comments were many and varied. Most comments have already been made in earlier sections of this report and relate to the importance of forming good partnerships, working collaboratively, the importance of dissemination and good communication skills.

Other lessons included the value of evaluation including learning from what did not work; the importance of project planning; and the ability to be flexible in project activities.

"Research can make a difference. Rigorous evaluation is worth the effort. Forming collaborative partnerships are the best way to develop a good model of practice in this setting. Effort of applying for grants is well worth it."

"It is important to realise the learnings from aspects of the project plan that did not work. There is a need to go through the relevant evaluation processes to help identify this and you need data to demonstrate it."

There were two recommendations for future programs. Firstly there was a suggestion to decrease potential duplication among projects by providing indicative funding. The second recommendation was to ensure that adequate resources are applied for in applications to realistically cover the project officer's workload.

15.2 What skills have you gained from your experience on this project?

Participants were asked to consider what skills they had gained whilst working in the role of project officer. Of the 23 projects who responded, the main skills gained were:

- Project management skills
- Liaising and negotiating with key stakeholders
- Evaluation skills
- Communication skills
- Public speaking skills
- Computer/IT skills
- Report writing skills

The fact that project management was the most common skill developed is perhaps understandable given the large number of first-time project officers working in the program. It is also not surprising to see that liaison and communication are mentioned so frequently given the consultative nature of most of the projects. It is pleasing to see that evaluation features so highly as a learned skill with so many first time project officers.

The development of public speaking skills is a reflection of the number of project officers that have presented at public forums and conferences including the Care Planning National Workshops.

15.3 Where to from here?

Participants were asked to consider what lay ahead of them in terms of their career once their time with the Care Planning Sub-Program comes to an end. There were 25 responses to this question, with nine project officers indicating that they would continue working for the host organisation. Of these nine, eight said that this would allow them to continue to develop and monitor elements of the Care Planning project.

The completion of the Care Planning project meant that three project officers had completed their period of secondment and were returning to their substantive clinical role.

Three project officers have commenced post graduate studies in health services research methodology, each opportunity coming from their involvement in the program. Another project officer will continue their PhD looking at end of life care in the residential aged care setting, and another will start a fellowship as explained:

"[The project officer] has received a fellowship (PHCRED Fellowship) designed for GPs and allied health professionals to develop their research skills in palliative and primary care. This opportunity came directly out of the project officer role."

Lastly, one project officer indicated that they are moving into a similar role in the area of advanced care planning.

15.4 Final question: Is there any thing else that you would like to add?

Seventeen projects indicated that they had additional comments to make. These comments were quite varied. Four project officers indicated that their experience of working in the Care Planning Sub-Program had been a very rewarding and enjoyable experience.

Five projects used this opportunity to provide DoHA with recommendations relating to managing future funding opportunities:

"... the submission process for the original tender was far too rushed and badly timed (over Christmas). This was an unrealistically short timeframe to make a thorough submission. The track record of the investigators should have been the key evidence of competence."

"Case conferencing is fundamental to the team approach of planning palliative care and communication. It is essential that the Commonwealth investigate how to fund this."

"It would have been good to have the ability to get a series of projects in each round of funding. There was a link between this project's funding and round 3 but it would have been great to receive round 2 and round 4 funding also. The project officer felt as though the different rounds of funding needed to fit together better. Each round should have built on the last."

"Three year projects are excellent as they are a good lever in attracting quality research staff to the organisation."

"...it was great to be able to have access to this type of funding that links national policy directions to state initiatives."

One project made the following comment about the Care Planning Sub-Program:

"It's good that the Commonwealth (Government) has an interest in care planning and is supporting it through this type of program. The department is being quite visionary in what it funds in terms of the national palliative care strategy and what is funded within that. Through the Care Planning Sub-Program they have given opportunities to groups without track records in research to try out new ways of working and do important projects. This

has built capacity in palliative care because it encourages practitioners to look at the way they are doing things and find improvements.”

16 Discussion

The exit interview sought to ascertain the perspectives of those people directly involved in managing a Care Planning project over a period of two to three years. The majority of the participants had been involved with the project since its inception, responsible for identifying service gaps and remedial strategies, negotiating with key stakeholders and building partnerships, and articulating these processes on a regular basis through their reporting requirements.

Their intimate knowledge of the detail of their projects, and their experience of managing, directing and ‘doing’ these project, provide them with invaluable insights in running palliative care projects. The structure of the exit interview process sought to seek their perspectives on lessons learned from their experiences, issues regarding project management, and support activities that were provided at a program level.

16.1 The value of exit interviews

The exit interview process was supported by all 33 projects. The projects appeared to have found the telephone format suitable, with interviews taking an average of 88 minutes, which is longer than the 20 minutes expected according to Shuy⁵. For this sub-program, where the relationships have been established with the projects over the past two or three years, a telephone interview is an appropriate method to gather data about the projects and the sub-program. In addition, the exit interview appears to be an important process to bring closure to the projects and the sub-program. It gave the projects an opportunity to reflect on the highs and lows, plus offer suggestions for improvements and recommendations for future projects and programs.

The projects offered comments on their projects activities in terms of what they gained, what they learned, what they did best and the difficulties they experienced. The two major lessons identified by project officers arising from their experience running a palliative care project were around the capacity of the sector and the importance of partnerships.

16.2 Capacity of the sector

Many projects identified an enhanced capacity of the sector to better deal with palliative care clients as a result of the education and training provided by the projects. This was not only on an individual level (i.e., as a recipient of training) but also on a systems level, with a number commenting that their organisations had an improved appreciation of the importance of sound palliative care planning.

16.3 Partnership issues

The value of partnerships was a further theme that emerged as one of the most fundamental components in care planning. Paradoxically, this also provided one of the most significant challenges for project officers. There were mixed messages from the projects about the preparedness of general practitioners (GPs) and Area Health Services to engage in care planning. A number of projects proactively developed strategies to encourage their participation in care planning, however there were mixed results reported when the project officers were asked about the success of these strategies.

The common ground between GPs and Area Health Services is the issue of resource constraints; for GPs it is in the area of time and how it can be managed in a fee for service context and for AHSs it is the budgetary constraint of managing capped programs. These findings about the

⁵ Shuy RW (2002) ‘In-person versus telephone interviewing’ (Chapter 26 in) Gubrium JF and Holstein JA (eds) *Handbook of interview research: context and method*. Thousand Oaks, CA: Sage, 2002.

practical difficulties of creating genuine partnerships have profound implications for the future of any care planning initiatives given that GPs and Area Health Services have such an integral role to play in palliative care.

16.4 Skills in planning and managing the projects

There were a number of project management lessons which were identified through the exit interviews regarding project planning, evaluation, reporting and skills development.

Overall, most projects felt that the funding was sufficient. However over half commented that there was not enough time, including some projects that needed more time to either embed the changes and/or ensure sustainability. A number commented that the initial project plan was overly ambitious, and not realistic given the timeframe or the budget, resulting in some projects renegotiating their contracts to reduce the scope of the project.

A project evaluation was not originally planned to be carried out by almost one third of the projects, and therefore factoring in evaluation in terms of timeframes, budgets and skill sets proved problematic for some. However, the interviews suggest that many did see that evaluation had merit, and a number of suggestions were made regarding future projects, including recommending evaluation tools and suggesting alternative methodologies. A number of projects commented on how the NET was able to encourage and support them to include evaluation activities.

A detailed final report was not part of the requirements at the outset of the sub-program. The NET sought to introduce a reporting template early on in the program to ensure there would be an end of project report that could be more widely disseminated. This process proved to be a challenge for some projects in terms of the skill set of the project officers and the time allocated to produce the reports. But even with these challenges, the projects that did complete the NET final report were positive about both aspects of the process and the outcome – a report on their project which tells the story of what they did and how it went.

The interviews also revealed that for a large number of projects, the ability to acquire project management and stakeholder engagement skills was a significant outcome. This is not surprising, given the NET's estimate that the majority of project officers were experienced clinicians with no or little prior project management experience.

Project officers commented that they have developed a number of skills from being part of this program, with project management, liaising and negotiating and evaluation skills being the most commonly cited. It appears that at least half of the project officers will be remaining in the palliative care, aged care, or health sectors. So the outcomes of the projects, plus the skills attained by the project officers themselves, will hopefully be maintained in the sectors.

16.5 More than the sum of the parts

The sum of this program is more than 33 individual projects. There were a number of activities and processes that were instigated by the NET and DoHA to bring the projects together. This appears to have been successful in developing the projects into a program. The role of the NET enabled the projects to be supported and linked together. The site visits (approximately 60 conducted) together with the three national workshops and the state forums proved to be an effective way to achieve this. Support provided to the projects by DoHA was positive, with officers being regarded as being interested, approachable and responsive.

17 Conclusion / Recommendations

The reasons for conducting exit interviews as a component of the evaluation were to give the opportunity to project officers to have their say about what was important to them and to provide a balance of quantitative and qualitative methods in addressing the important issues around the sustainability, capacity-building and generalisability questions for the projects⁶.

This approach has been used previously by the Centre for Health Service Development in its development of mixed methods of evaluation research, geared to service improvement⁷. It makes sense to provide an opportunity for projects to reflect not only on the outcomes of their activities, but also the processes of undertaking the projects. This process of reflection can provide key lessons for policy and program administrators when seeking to establish projects of this nature in the future, as well as assisting project officers better anticipate the requirements and potential difficulties they will face in running projects such as these.

The experiences of the Care Planning Sub-Program projects echoes those of others we have worked with, and they provide valuable lessons for project administration and management in the health and care related sectors.

Specific care planning lessons

The most common message from projects in the exit interviews was the importance of partnerships in providing good care for people with palliative care needs. One of the key partners in this process is the GP. However, many of the projects had mixed findings relating to the success of engaging GPs in a collaborative approach. Where this worked well, it had very positive outcomes for clients; however, for others the engagement of GPs was too problematic and proved to be unsuccessful. This is consistent with previous findings in this area⁸.

Specific project management lessons

From a project management perspective many lessons can be gleaned from the exit interviews. With regards to reporting requirements there was some agreement that a final report template should be included in the application process which provides the opportunity for projects to report in more detail about their experiences, outcomes and lessons learned and not just simply on what the projects did. It was also felt that to avoid unnecessary duplication, the six-monthly project progress reporting templates should be combined with one report going to both DoHA and the NET.

Many of the projects felt that the provision for evaluation and an evaluation plan should be more explicitly built in and made mandatory as a part of the application process. This would better enable projects to plan and budget for the various important evaluation activities.

Further, with regards to evaluation, it was recommended that a National Evaluation Team should be involved from the start of the program funding period. This would enable the national evaluators to recommend common evaluation methods and evaluation tools and avoid costly duplication of effort.

⁶ Pope C and Mays N (2009) *Critical reflections on the rise of qualitative research*. *British Medical Journal*, Vol. 339: b3425 doi: 10.1136/bmj.b3425come

⁷ Masso M and McCarthy G (2009) *Literature review to identify factors that support implementation of evidence-based practice in residential aged care*. *International Journal of Evidence-Based Health Care*, Vol. 7, No. 2, pp. 145-156.

⁸ Masso M and Owen A (2009) *Linkage, coordination and integration – evidence from rural palliative care*. *Australian Journal of Rural Health*, Vol. 17, pp. 263–267.

The exit interviews also revealed that some of the project officers felt over-burdened by the challenges of managing a project. In view of this, future programs may consider facilitating a greater focus on project management training for the project officers as required, e.g. evaluation methods, data analysis and/or report writing.

Another lesson for projects is the importance of being realistic about their project plans in terms of what they can actually achieve in a set amount of time with a specific level of funding. In many cases project officers felt that their project plans were unrealistic in terms of their timeframe and the funding provided. Many felt that it was better to try to achieve a realistic set of goals and objectives, and do this well, rather than trying to achieve too much and do it less efficiently and with less impact.

Appendix 1 – Care Planning Project Exit Interview Template

Project Number		NET member	
Project Member/s interviewed		Interview date	

Start of the interview

1.1 Program objectives:

Objective	DoHA	Site visit	Project end
1) Develop and implement flexible models of service delivery that meet the needs of each palliative patient in their local community			
2) Improve collaboration between services involved in providing care			
3) Support the smooth and appropriate transition between settings of care, i.e. residential aged care facilities, the person's home and inpatient facilities			

1.2 Program objectives comments:

1.3 Project objectives: How did the project related to the program objectives?

1.4. Key themes:

Theme	DoHA	Site visit	Project end
a) Resources and tools			
b) Strategies that involve carers and families in planning for care at key stages			
c) Projects that develop and trial strategies or models of care that enhance care planning			
d) Projects that address the needs of particular groups (e.g., residential care, children, Aboriginal)			
e) Activities to support the translation of research on care planning into policy and practice			
f) Projects to promote and support high quality evaluation in the palliative care planning area			

1.5 Key themes comments:

1.6 Other themes of the project?

2. Project activities

2.1 What did your project gain?

2.2 What did your project learn?

2.3 What did your project do best?

2.4 What (major) difficulties did your project encounter? Were they expected? Were they resolved? If so how?

3. Support and resources available to the project.

To what degree did you find the following sufficient? How could any of these processes been improved?

3.1 Funding: Was the funding sufficient?

3.2 Time: Was the time frame realistic?

3.3 Local support: in-kind/ organisational support (including *key stakeholders*)

4. Evaluation:

4.1 How did the evaluation go?

5. Reporting

To what degree did you find the following useful? How could any of these processes been improved?

5.1 Two reporting templates - Progress report templates (DoHA and NET ones)

5.2 Final report (using the 1:3:25 template) including the final report guideline document and the support by NET?

6. Program activities

To what degree did you find the following useful? How could any of these processes been improved?

6.1 Site visits:

6.2 Annual workshops

6.3 State Forums:

6.4 List server:

6.5 Information Bulletins:

To what degree did you find the following useful? How could their roles and/or services been improved?

6.6 DoHA officers:

6.7 NET:

6.8 Any one else?

7. Sustainability, capacity building and generalisability issues (Tool 4-6)

Complete the final tool with the interviewer (or could be completed prior to interview) and then answer the following questions (leading on from the tool).

7.1 Sustainability: What aspects of your project will continue? How did you ensure this?

7.2 Capacity building: Do you think your project helped build capacity in palliative care? How?

7.3 Generalisability: What aspects of your projects can be transferred or used elsewhere?

8. Dissemination:

8.1 Did you have a dissemination plan at the outset? Did it change over the course of the project?

8.2 What activities worked best for your project?

9. Conclusion

9.1 What lessons will you take away from your experience on this project?

9.2 What skills have you gained from your experience on this project?

9.3 Where to from here?

9.4 Final question: Is there any thing else that you would like to add?

End of the Interview

Appendix 2 – Care Planning Project Exit Interview (Original Template)

Project Title:
Project Member interviewed:
NET Member:
Interview Date:

Questions

1. What did your organisation gain from being part of the Care Planning Sub-Program?
2. What did you learn?
3. What did you do best?
4. Did you encounter any major difficulties? What were they?
5. What could you have done better?
6. Tell me about the support and resources available to the project.
 - Was the funding sufficient?
 - Realistic time frame?
 - In-kind/ organisational support sufficient?
 - What about the role of the DoHA officers?
 - Role of the NET?
7. Did your project use tools from the evaluation tool kit provided? If not, why not? If you did use them did they prove useful? Could any of the tools be improved? What evaluation tools did you develop? Do we have copies?
8. Did you find the annual workshops useful in terms of the evaluation of your project?
9. Was the evaluation process useful? How?
10. What aspects of your project will continue? How did you ensure this?
11. What aspects of your project can be transferred or used elsewhere? E.g. model/methods/tools/products
12. Do you think your project helped build capacity in palliative care? How?
13. Is there any thing else that you would like to add?

Appendix 3 – Sustainability, capacity building and generalisability issues tool

Care Planning Sub-Program Evaluation Tool

Sustainability, capacity building and generalisability issues

Introduction and instructions for use

Purpose

This tool has been developed to assess the organisational and system level impact of projects within the Care Planning Sub-Program. It is expected to contribute to the national evaluation in two ways:

1. The tool enables us to collect data and answer questions about impacts of the projects. When aggregated, these data can inform us about program impacts and outcomes.
2. The tool highlights issues which, if projects choose to address them through appropriate strategies and activities, are likely to enhance sustainability, capacity building and generalisability.

Definitions

Sustainability – how likely is it that project impacts will continue beyond the life of the program?

Capacity building – does the project develop skills and knowledge in palliative care services and systems?

Generalisability – can project methods and findings be applied elsewhere in the palliative care community?

How will the tool be used?

This tool will be used at the beginning and end of the project. It will be completed by the project officer, in discussion with a NET member at a site visit or telephone interview. Where possible, a project sponsor/manager/steering committee chair should attend and contribute to the discussion.

First, complete the checklists. The action lists at the end of each section provide a place to record any existing strategies and activities that contribute to sustainability, capacity building and generalisability, along with any suggested additional strategies and activities that may be needed.

A copy of the completed tool will be given to the project officer and may subsequently be used to stimulate discussion with project sponsors/managers/steering committees about additional strategies and actions that may reasonably and realistically be taken to enhance sustainability, capacity building and generalisability.

Projects will be asked to report on the strategies and activities identified in this tool as part of their six-monthly report to the national evaluation team.

It is very important to rate your project **as it is now**, and not how you want it to be at some point in the future. Therefore at the beginning of the project it is likely that there may be a greater proportion of lower scores or answers of "don't know" than there will be at the end point of the project.

How was the tool developed?

The first three sections (project characteristics, staffing issues and organisational factors relating to sustainability) were adapted from a Sustainability Model developed by the NHS Institute for Innovation and Improvement⁹.

The remaining sections were developed at the CHSD and have been used in previous evaluation projects. Section four (relationships with partner agencies) is built on the assumption that a key success factor in maintaining any gains or innovations implemented during a project is the strength of networks and partnerships built with stakeholders. Questions in section five (capacity building issues) are an extension of the sustainability questions and refer to skills and knowledge gained, or support for ongoing changes within a system, resulting from a project. Section six (generalisability) captures information about broader impacts of projects, beyond their immediate local service area or target group, and whether evaluation findings can be applied to other settings and circumstances.

⁹ Maher L, Gustafson D and Evans A (2006) NHS Sustainability Model [Available online]: http://www.institute.nhs.uk/NR/rdonlyres/9E4B7EA0-C338-4F35-9FE4-D797C704B986/0/ST_SECTION01.pdf

Care Planning Sub-Program Evaluation Tool

Sustainability, capacity building and generalisability issues

Care Planning project details	CODE	Project officer's name
	Project title	
	Host organisation	
Date tool completed		Timing (circle one): Initial / Final

What is your goal after the pilot funding ends (please select one only)?

☐ The project will be over and its impact will end soon after

☐ The project will be over but it will keep having an impact

☐ By the time the funding ends, we will have found other ways to keep the project going

Please tick the box that best represents your view

No	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable	Comments
Section I: Characteristics of the project likely to enhance its sustainability								
1	The project will improve the efficiency of palliative care services							
2	Staff will notice a positive difference in their working lives as a result of the project							
3	Benefits of the project are immediately obvious							
4	Stakeholders are aware of the benefits of the project							
5	The new processes introduced by the project do not rely on a single individual or group, technology or funding source to continue							
6	There is a system in place to monitor progress and initiate action as a result of feedback							
Section II: Issues affecting staff (not the project team), who are involved in implementing changes introduced by the project								
7	Staff have been involved from the beginning of the project, and their ideas influenced the change process							
8	Staff have been adequately trained to implement and sustain the new processes introduced by the project							

No	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable	Comments
9	Staff believe the new processes introduced by the project are a better way of doing things							
10	There is someone in authority or senior management, other than the project manager, who is an advocate for the project with staff							
11	Clinical leaders have been involved in the project and will promote it to staff							
12	Systems are in place to ensure staff can share information with, and seek advice from, managers and clinical leaders							
Section III: Organisational factors which affect how long projects last								
13	The host organisation has a history of successfully sustaining improvement							
14	The goals of the project are consistent with the host organisation's strategic aims							
15	Staffing levels are adequate to enable the new processes introduced by the project to be sustained							
16	Facilities and equipment are available to support the project							
17	Policies and procedures have been developed to support the project							
18	Systems are in place to ensure the project team can communicate with stakeholders							
Section IV: Relationships with partner agencies								
19	The project has improved communication between participating agencies							
20	The project has positively changed relationships between participating agencies							
21	The project has resulted in a more streamlined and coordinated service for palliative care clients							
22	The costs of the changes implemented by this project are greater than the benefits							
23	Protocols and tools developed during this project will be adopted for routine use after it is over							
24	The project has demonstrated that relationships between agencies at the local level can be changed by the use of formal policies and protocols							
25	Projects such as this one help to strengthen relationships between agencies							

No	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable	Comments
26	Projects such as this one provide important local lessons in how to do things better							
Section V: Factors within the organisation's setting that relate to capacity building								
27	This project has been able to establish agreed policies or procedures with other organisations regarding the provision of palliative care services							
28	This project has generated and supported local skills to direct, provide, lead or otherwise contribute to the provision of palliative care services							
29	More organisational resources have been directed to the area of palliative care services in this community as a result of this project							
30	The project has involved formal and/or informal training of people whose skills and interests will be retained in the project or its immediate environment							
31	The project was designed to enable people not directly involved in the project to develop capacity (skills and/or knowledge) to provide palliative care							
Section VI: The generalisability of the project								
32	The project has been designed specifically to meet our own local needs							
33	Other regions/services/organisations will learn useful lessons/information from the project							
34	It is reasonable to expect that our outcomes could be replicated elsewhere							
35	The success of the project depends on how flexibly it can be implemented according to local circumstances							
36	We already have a strategy in place to ensure that our experience and findings are shared with other people who want to develop and improve palliative care services							
37	By the time the project ends, we will have a strategy in place to ensure that our experience and findings are shared with other people who want to develop and improve palliative care services							
38	Projects such as this one provide important lessons for other regions in how to do things better							

Based on the responses and comments above, briefly summarise the strategies that are already in place (refer to project documents where relevant). Then identify priorities for additional strategies. There may be more or less than four strategies in each section – this table is a guide only. Projects will be asked to report on the strategies listed below in their six-monthly and final evaluation reports.

Strategies relating to Sustainability
1.
2.
3.
4.
Strategies relating to Partnerships
1.
2.
3.
4.
Strategies relating to Capacity Building
1.
2.
3.
4.
Strategies relating to Generalisability
1.
2.
3.
4.