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Evaluation of the Rural Health Boards of Management Development Program

(March 2006)

Recommendations
Recommendations

Note:
- Recommendation 4 is not included. The successful tenderer will be advised on this.
- Recommendations 5a and 8a are not included - they relate to internal Departmental policy.

1.1 Future Rural Health Board Governance Training

**Recommendation 13:**
That the concept of governance training for rural boards of management should be expanded to four levels of training including:
- Local induction training and orientation;
- Comprehensive training on health service governance based on the current RHBOM Development Program;
- Regional training focusing on specific health care topics; and,
- Local training/coaching in the functioning of a board.

1.2 Program Administration And Management

**Recommendation 1:**
That a similarly representative Reference Group be established to guide any future DHS governance training.

**Recommendation 12:**
The theory of ‘diffusion of innovation’ and the ‘Tipping Point’ concept should be adopted to assist DHS in estimating the demand for future governance training. This approach can also assist in assessing the characteristics of board members to be selected to attend training.

1.3 Two Day Program Course Content

**Recommendation 7:**
Future iterations of the workshops should continue to incorporate the opportunity for informal networking over meals, but utilize the opportunity to collectively and systematically review training topics from the preceding workshop.

**Recommendation 9a:**
The workshop documentation should state ‘learning outcomes’ rather than ‘learning objectives’. This will emphasize what board members should know and should be able to do – that is, focus attention on changing board practice.
<table>
<thead>
<tr>
<th>Recommendation 9b:</th>
<th>The information provided about the experience and expertise of presenters should relate to the topics they are teaching in the Program.</th>
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<tbody>
<tr>
<td>Recommendation 9c:</td>
<td>Active participation should be shown in the workshop timetable and the principles of adult learning should be stated alongside the learning outcomes.</td>
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<tr>
<td>Recommendation 9d:</td>
<td>The clinical governance presentation should provide participants with an understanding of the key processes they will need to understand and assess best practice e.g. adverse occurrence screening, sentinel events, root cause analysis, clinical indicators, credentialing clinical audit, and the model for improvement.</td>
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<td>Recommendation 9e:</td>
<td>The presentation should promote the value of establishing a safety and quality committee equivalent in status to the finance committee.</td>
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<td>Recommendation 9f:</td>
<td>A Victorian example of failure in clinical governance should be used for group discussion rather than giving examples from other jurisdictions.</td>
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<td>Recommendation 9g:</td>
<td>The ‘decision tree’ should include the reporting structure from the board downwards.</td>
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<td>Recommendation 9h:</td>
<td>Learning outcomes should focus on providing a “whole of system thinking” approach taking account of contemporary trends in health services such as the prevalence and management of chronic disease in primary care.</td>
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<td>Recommendation 9i:</td>
<td>A presentation on how clinical and non-clinical risk management plans are developed for and managed by boards is necessary with particular emphasis on clinical governance aspects.</td>
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<td>Recommendation 9j:</td>
<td>Learning objectives should be expanded to encompass the role of ‘whistle blowing’ in contemporary health services.</td>
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<td>Recommendation 9k:</td>
<td>The tool provided in the two-day workshops on strategic planning should be re-designed, as it is unlikely that board members would have sufficient information about their particular health organisations to do the task in the first workshop.</td>
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</table>
**Recommendation 9i:**
The materials and presentation of clinical governance and financial management (clinical and non-clinical risk management) need to be re-written so that board members can understand and manage the tension that sometimes arises between financial and clinical governance priorities and have the vocabulary to ask the right questions and know what the appropriate reporting templates should be.

**Recommendation 9m:**
Board members should be taught through role-play how to discharge their responsibilities in managing the CEO especially in encouraging their responsibility to promote the culture of a learning organisation.

**Recommendation 9n:**
The use of videos as an instructional medium to illustrate “groupthink” and other group processes should be included in the presentation.

**Recommendation 9o:**
The concept of media handling should be incorporated to assist board members to understand how their organization should operate a media policy.

**Recommendation 9p:**
All case studies should be accompanied by a single take away presentation containing key learning points. This recommendation would apply to other case studies and exercises in the workshop materials that engage participants in discussion.

**Recommendation 10:**
DHS rural Regional Directors should develop a standard presentation covering:

- The drivers for change in the health policy e.g. focus shift from acute to a comprehensive primary health paradigm;
- Financial drivers including case mix and aged care funding;
- An overview of key aspects of population health;
- The importance of factoring demographic drivers into strategic and service planning; and
- An overview of the health service at the regional level and how it operates as a system.

**Recommendation 11:**
Future training should focus on equipping trainees to introduce change ideas to their board on their return: e.g.

- Providing them with a checklist of change ideas to take back to their boards to promote the diffusion of innovative ideas for reform; and
- Briefing them on how best to introduce ideas for change.
1.4 Program Distribution

**Recommendation 6:**
Potential barriers to board member participation in governance training should be addressed by:

- Adopting training models that are designed to minimise barriers for attendance such as personal inconvenience of travel and time availability (e.g., the Four Level in-house, regional and sub-regional model outlined in this report);
- Better long-term planning of the sequence and location of training sessions;
- Introducing a long-term plan to improve marketing (by CEOs and DHS); and
- Introducing structural changes to reinforce the importance and desirability of training e.g., Annual reporting, inclusion in model rules etc.

**Recommendation 8b:**
That future programs use an over-booking approach with wait lists to ensure that the maximum capacity of the Program is utilised.

**Recommendation 8c:**
That responsibility for establishing priority wait lists to attend be undertaken by DHS Regional Directors in conjunction with CEOs and Chairs.

1.5 Program Reporting And Evaluation

**Recommendation 2a:**
The actual ratings provided by participants in the pre-test and post-test evaluation sheets should be graphed side by side.

**Recommendation 2b:**
The information derived from the pre and post evaluation sheets completed by participants should include the number of valid responses under each table/graph in order to clarify results and give credence to interpretation.

**Recommendation 2c:**
The response scale used in the reports to DHS should be recalibrated to show a normal distribution with neutral midpoint.

**Recommendation 2d:**
Provide range or standard deviation statistics when reporting means.

**Recommendation 2e:**
Participants should be given separate Workshop evaluation instruments assessing their knowledge of the various factors pre-workshop (Time 1), post-workshop (Time 2) and at follow-up (e.g., 4 months post-completion) (Time 3).

**Recommendation 2f:**
Statistics should demonstrate change within individuals/groups over a period of time. Interpretations should acknowledge the subjective or objective nature of the measurements.
**Recommendation 3a:**
Future reporting on the performance of the program should include DL Kirkpatrick’s Level 4 achievements.

**Recommendation 3b:**
A range of pre-determined categories that reflect key Level 4 outcomes should be adopted to support future thematic analyses.

### 1.6 Promoting & Marketing The Training Program

**Recommendation 5b**
That all opinion leaders (e.g. the Minister, DHS Regional Directors, board chairs and CEOs) strongly encourage board members to attend governance training and development programs.

**Recommendation 5c**
As part of their role in improving their organisation’s performance and capacity, board chairs and CEOs should regularly assess individual members’ knowledge of governance as well as practice and advise individuals on appropriate training options.

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