Aims: In an environment of collegiality and openness to provide an opportunity for:

- Health management academics, research students and professionals with an interest in education and workforce development to explore issues and opportunities
- SHAPE members to discuss State and program issues and developments
- Academics and higher degree students to discuss their research ideas, plans and methodologies and explore current and new research and curriculum directions in a supportive environment
- The development of future strategies relating to SHAPE’s objectives
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<td>Using text analysis and concept mapping to online discussions to</td>
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| 1800 - 2000| Host: David Briggs, President, SHAPE Welcome Reception for all delegates
              Venue: La Trobe University Melbourne City Campus
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<td>1. Diana Messum, Lesley Wilkes &amp; Kath Peters, Western Sydney University &amp; Debra Jackson, Oxford University Hospitals, NHS Trust</td>
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<td>5. Anneke Fitzgerald, Gaery Barbery, &amp; Kathryn Hayes, Griffith Business School</td>
<td>From implementation theory to changed practice: The road to a “new normal” travelled by implementation savvy health service managers</td>
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| **Session 6**  
**Chair:** Anne Smyth  
**Speaker:** Kim Koop, CEO VICSERV - peak body representing community managed mental health services in Victoria | *The health and community service system: what educators and practitioners need to understand about what happening NDIS and beyond - what kind of managers do we need?* | 0900 - 1000 |
| Morning Tea | | 1000 - 1020 |
| **Session 7**  
**Chair:** Mark Mackay | | |
| 1. Marie Dickinson, University of Technology Sydney | Understanding the reasons behind less than expected health professionals engagement in quality | 1020 - 1040 |
| 2. Inge Dhamanti, Sandra Leggat, & Simon Barraclough, La Trobe University | Under-reporting of patient safety incidents in Indonesia: a mixed method study | 1040 - 1100 |
| 3. Sandra Leggat & Cathy Balding, La Trobe University | Quality systems 101: Implications for post graduate education | 1100 - 1120 |
| 4. Charissa Zaga & Sandra Leggat, La Trobe University | Consumer participation and public reporting of quality of care in hospitals | 1120 - 1140 |
| **Chair:** Sandra Leggat | Launch of the research e-book | 1140 - 1200 |
| **Chair:** David Briggs | Pulling the threads together, next steps, next year’s symposium and initial feedback  
Symposium closure | 1200 - 1230 |
| Lunch | | 1230 - 1330 |
ABSTRACTS

Using text analysis and concept mapping to online discussions to improve Health Care Management teaching
Mark Mackay & Janny Maddern, Flinders University

The shift of education courses from being delivered in a purely face-to-face mode to a mixed mode of face-to-face and online delivery has been fuelled by a number of drivers including technology, cost and convenience. The change in delivery modes has been accompanied by new delivery practices intended to facilitate continued student engagement with the subject and networking with peers.

Online discussions have been implemented as part of many of the subjects taught as part of the health care management courses to facilitate student engagement with the subjects. Such opportunities also enable students to share opinions and experiences, and learn from each other.

Such discussions can be conducted in a synchronous manner (i.e. everyone attends the online session at the same time) or in an asynchronous manner, where people can choose when they post their comments within a defined window of time. The latter method provides students with flexibility, which is particularly important for postgraduate health care management students who are largely working full-time and studying part-time.

The way in which we use online discussion topics is to provide students topical scenarios in order that they can apply their learnings on current issues of interest and relevance.

The flexibility provided by the online environment can be both positive for the student or challenging. We have found that some students will provide their responses very late in the window of opportunity that is provided for the discussion, thereby limiting their contribution and ability to engage in more deep and meaningful discussion. Anecdotally, it is evident that the both the number of contributions and volume of contribution differs across students, particularly in relation to the time when the responses are made.

We are interested in the application of text analysis and concept-mapping, in conjunction with other performance measures including student grade and the time of submission, to analyse the online comments in a structured manner in order to identify the how students participate in this educational activity better understand opportunities for improving the learning and engagement opportunity for students.

Language and management
Simon Barraclough, La Trobe University

Some of those involved in management are sometimes especially criticised for their use of jargon, cliché, obfuscation, ugly expression and euphemism, as well as following fads in language. Language is recognised as a form of power and is therefore worthy of understanding in the management setting. This session will seek to raise consciousness about some of functional, cultural and ethical issues associated with the way we communicate through the spoken and written word. It will also be argued that educators of health managers should strive to motivate their students to speak and write in plain language which is both ethical and accurate and does not represent the misuse of power in relationships.
Implementation planning of the National Health Plan (NHP) in the decentralised health system in Madang province of Papua New Guinea

Tabian Ambang, La Trobe University

This study investigated the implementation planning of the National Health Plan (NHP) in Papua New Guinea (PNG). The study was conducted in one of the provinces of PNG (Madang province) with an aim to provide an understanding of the implementation planning of the NHP in a decentralised health system. Review of the literature on the topic shows that National health policies and plans were no implemented successfully since the administrative functions of the rural health services was decentralised to the district administrations in PNG (Asante & Hall, 2011; Thomson & Kase, 2009).

The design of the study was based on a qualitative research methodology (Guba, & Lincoln, 1994). Data was collected using interview and written documents. Face-to-face individual interview was conducted with key informants (n=25) using a structured open-ended questionnaire. Health provider’s program activity implementation plans were also examined to seek evidence of NHP implementation planning. Data was collected from the main provincial health office (n=1), District Health Office (n=4), Rural hospitals (n=2) and Health centres (n=10). Data analysis started with content analysis to identify codes and to display the pattern in the data using frequency tables and charts. Further analysis to identify themes and to interpret and explain the pattern in the data was done using thematic analysis (Braun, Virginia & Victoria, 2006).

The findings of the study provided understanding on the complexity of program activity implementation planning in a decentralised health system. The study also provided understanding of the challenges experienced by the health managers on program activity implementation planning in a decentralised health system. Decentralisation has created a complex environment for health program activity planning in the provinces and districts in PNG, resulted from autonomy enjoyed by the provinces and districts. The health managers in the districts not only align their program activity plan with NHP but also with district and provincial development plans. There was no clear implementation planning framework, and many health managers in the districts lack understanding NHP. As a result there was no sense of NHP ownership at the facility level which could affect PNG’s progress on achieving PNG Vision 2050. The study suggested for an integrated implementation framework for all national policies at the local level to ensure strategic alignment with national direction, focus and vision.

References


Thomason, J. & Kase, P. (2009), Policy Marking in Health, Chapter 7 in May, J, Policy Making and Implementation: State and Society, No.5 pp. 117-130

Establishing a Health Systems Management College at Naresuan University Thailand: International collaboration
David Briggs & Phudit Tejativaddhana, Naresuan University, Thailand

Naresuan University has established a College of Health Systems Management and is developing curricula to deliver a health system management program through existing Master of Health Sciences frameworks delivering a Masters by coursework and research through two streams and a PhD. The academic staff are being recruited from across Faculties at Naresuan University. The program will be delivered in the English language and an international advisory committee is being established. The student cohort is anticipated to be multidisciplinary including Thai health professionals and will also accept students from countries in the sub region. It will be the first health management program established in Thailand and the University is seeking international support including that of SHAPE in curriculum development and meeting quality and accreditation standards.

Beyond the numbers: On the road to achieving public value in community support organisations
Fiona Girkin, Kate Ellen Elliott, Elizabeth Shannon & Craig Zimitat, University of Tasmania

Demonstrating the value of a community support organisations (CSOs), can be challenging. Measuring community impact and client outcomes beyond “numbers through the door” can provide an understanding of the value of CSOs to consumers, the public and Government. One way in which outcomes can be measured is through considering the value provided by a service to the public. Public value (PV) is a framework which has been used as a vessel for understanding the activities of Government and clarifying policy and service delivery (O’Flynn, 2007). In essence, “public value creation is the process of adding value to public sector organisations through the exercising of increased managerial autonomy” (Grant et al., 2014, p. 18). The value provided by CSOs could potentially be evaluated with this same framework which has previously served as a structure for health care improvement (Porter, 2010) to benefit all key stakeholders including individual consumers, organisations and Government.

Government is typically responsible for creating an environment and resources to provide PV, while the organisation generates the social impact within the environment (Alford & Hughes, 2008). Commonly PV has only been used as a governance tool for performance measurement (Alford & O’Flynn, 2009) and to determine decisions about budgets, policies and laws (Chapman, 2005), however, it is proposed that PV can be used to facilitate mutually beneficial partnerships and collaboration between Government and CSOs. The PV Framework has primarily been used in the public sector and to date there has been little application of the concept of PV to CSOs.

The PV Framework encourages managers to seek out opportunities for change that can increase value for money and improve services to the public within current resources (Moore, 2013). By understanding what the public need and providing services to fill any identified gaps PV is created; building trust between the community and Government or CSOs. Trust is at the centre of PV and fulfils the desire for freedom and security and the need for flexibility and control (Talbot, 2008).

This research project suggests that the concept of PV can be applied to CSOs as a tool for evaluating services and as a vessel for understanding the broader value these services provide beyond the services delivered. PV could be used as a quality improvement framework to provide increased service efficiency and quality, better outcomes for consumers and communities, and greater consumer confidence in Government health investments. This presentation will explore the potential use of PV by CSOs in the contemporary Australian social environment and seek feedback on whether a generic or specific service approach would be most useful when applying the PV framework in the private sector.
References

Does clinical supervision of health professionals improve patient safety? A systematic review and meta-analysis
David A Snowdon, Sandra G Leggat & Nick F Taylor, La Trobe University

Purpose: To determine whether clinical supervision of health professionals improves patient safety.

Data Sources: Databases MEDLINE, PsychINFO, CINAHL, EMBASE and AMED were searched from earliest date available. Additional studies were identified by searching of reference lists and citation tracking.

Study Selection: Two reviewers independently applied inclusion and exclusion criteria. Thirty-two studies across three health professions (medicine (n=29 studies), nursing (n=2 studies) and paramedicine (n=1 study)) were selected.

Data Extraction: The quality of each study was rated using the Medical Education Research Study Quality Instrument (MERSQI). Risk ratios (RR) were calculated for patient safety outcomes of mortality, complications, adverse events, reoperation, including conversion to more invasive surgery, and readmission to hospital.

Results of data synthesis: Meta-analysis of nine trials with 6,484 participants provided moderate quality evidence that direct supervision of surgery significantly reduced the risk of patient mortality when compared to unsupervised surgeries (RR 0.68, 95%CI 0.50 to 0.93, I²=33%). Meta-analysis of three trials with 241 participants provided moderate quality evidence that direct supervision of surgery significantly reduced the risk of patients requiring conversion of surgery to a more invasive procedure when compared to unsupervised surgeries (RR 0.39, 95%CI 0.22 to 0.69, I²=0%). Direct supervision of non-surgical invasive clinical procedures also appears to be associated with a reduced risk of patient harm.

Conclusions: Clinical supervision was associated with safer surgery and other invasive procedures for medical practitioners. There was a lack of evidence about the relationship between clinical supervision and safer patient care for non-medical health professionals.
The development of a competency model for allied health managers

Ka Hi Mak, School of Business, Western Sydney University

The professionalisation of allied health (AH) professionals and their positions within an organisation make them unique and different from their medical and nursing counterparts. AH professions were viewed as auxiliaries and their roles were to assist the medical profession in investigation and treatment. This significantly influences the AH clinical autonomy and professional identity (Jones & Jenkins 2006).

In addition, an AH professional’s impact on organisational targets, such as patient flow, is often indirect. Therefore, they often feel less powerful and influential than their medical and nursing colleagues. In addition, with limited budgets within the healthcare organisation, resources are often re-allocated to the medical and nursing domains. As a result, AH managers in public hospitals often feel frustrated and powerless enacting their management roles ultimately influencing their ability to demonstrate management competencies (Guillén & Saris 2013).

In health care organisations, hybrid managers are often employed carrying both clinical and managerial roles. At present, the majority of the literature is focused on hybrid managers in medical and nursing. There is a lack of research in understanding the roles and challenges faced by the hybrid-managers in AH. Since AH managers carry both clinical and managerial responsibility and are required to mediate between the two domains, they need to acquire certain characteristics to master this role.

Human capital is the key to the success of an organisation, therefore, it is important that health care organisations invest in developing a strong management team, including AH. The aim of this research is to develop a competency model for AH managers in acute hospital setting within South Western Sydney Local Health District.

This research uses a two-phase mixed methods design starting with quantitative data collection (online survey) followed by qualitative data collection (face-to-face interviews). For the qualitative phase, a grounded theory approach will be used. This approach generates ground theory from the research participants who have experienced the process. Since there is a lack of literature on competency models for AH managers, this approach utilises AH managers’ and their supervisors’ experiences to develop a competency model as well as theory.

This research will identify the essential characteristics that an AH manager should possess to perform his/her job effectively in an acute hospital setting. By understanding these essential attributes and applying this competency assessment model in the workplace, an organisation can improve its recruitment and selection processes, enhance induction processes and continuing education programs with the aim of reducing employee turnover.

References


Jones, R & Jenkins, F 2006, 'Development and significance of the profession in AHP management', in R Jones & F Jenkins (eds), Managing and leadership in the allied health professions, Radcliffe Publishing Ltd., Oxon, United Kingdom.
Soft skills in health services management: Perceptions of students, graduates, academics and industry on their importance
Tae McKnight & Alex Kristovics, Western Sydney University

Health Services Management (HSM) is an emerging field in health, which is becoming more formally recognised due to an increase in demand for health services. Subsequently, expectations of a graduate’s abilities are increasingly in demand. The Graduate Outlook Survey in Australia strongly identifies however that graduates non-discipline specific skills, otherwise known as Soft Skills (SS), are in deficit. To ensure competent Health Service Managers, there needs to be a skill shift in theoretical knowledge to concrete application in the workplace. Further, The World Health Organization and Australasian College of Health Services Management identify these skills and imperative for future managers. Yet, the SS research agenda is still predominately atheoretical causes confusion in the definitions, identification and implementation of SS. Industry and academia have an expectation of what they want included in a graduate’s skillset, however, it is not clear whether this skillset actually meets sector needs or is in line with student’s capabilities. The expected research will investigate the degree to which students, graduates, academics, and industry professionals value the teaching of SS and what factors underlie their reasoning. The research will explore the current atheoretical nature of SS that are identified in graduate competencies and begin to examine the possibility of a structured theoretical scaffold to these skills in curriculum. Using an adapted competency profile model the perceived importance of SS profiles between HSM academics, Industry students and graduates will be assessed.

References
Is competence enough for health service managers of the future?
Andi Sebastian, Consultant

As new items are added to primary and secondary school curriculum there is always a battle to find space in an already crowded list of essential items a teacher must address. Too often, the cumulative effect of a crowded curriculum is such that good teachers look for ways out of teaching.

Is this also true for health service managers in Australasia? Are we heaping area of competency upon piles of areas of competency such that health managers give up or skate through appearances rather than be totally overwhelmed? Who is keeping watch on the competencies health service managers must have and are they all essential, or are some optional and could be shared rather than all located in one person?

Is the focus on competent managers distracting from a thoughtful focus on enabling environments and a clear and unequivocal goal that provides a principle platform for shaping actions and decisions? And what of all the emerging evidence about the need for greater capability in the face of complexity and complex systems?

While there is evidence that ‘competent managers are one of the key contributors to effective and efficient health service delivery’, there is also evidence that our health systems are failing to be as effective and efficient as we would wish and that the challenges are increasing. In this context then, how might we view competencies for health service managers and what role do learning systems play in helping them address future challenges.

References
Liang, Z, Howard, PF, Koh LC & Leggat, S 2012 ‘Competency requirements for middle and senior managers in community health services’, Australian Journal of Primary Health 19(3) 256-263 http://dx.doi.org/10.1071/PY12041

Identifying key competencies to support health system reforms
Jalal Mohammed, Nicola North & Toni Ashton, University of Auckland

Health system reforms have been implemented in the health sector since the 1970s as a means to encourage efficiency, equity, effectiveness, quality and access. However, globally and across Australasia, health system reforms have not yielded intended outcomes. Fiji provides two contrasting examples of the need for the development of management competencies to support reform efforts. The first, a major reform effort undertaking a prescribed approach, lacked competent health managers to support reform efforts. The second, a context-specific incremental approach, is on-going in its implementation. The Ministry of Health has viewed the second reform effort as being successful in achieving its intended outcomes. As part of a broader study examining the second reform effort, a qualitative study consisting of semi-structured interviews with senior administrators and health managers of decentralised health facilities was undertaken. Key management competencies needed to support this second reform effort identified by interviewees were: organisation and service planning; interpersonal and communication skills; administration and resource management; evidence-based decision making; political skills; public relations; networking; negotiation and conflict resolution; information management and leadership. Further studies are needed to identify which competencies are needed at different management levels and at different types of health facilities. This will allow the Ministry of Health to develop specific competencies at different management levels and facilities to support health reforms.
The Adventures of Health LEADS Australia
Elizabeth Shannon¹, Meagan Crethar² & Paula Brown²
1 University of Tasmania  2 Department of Health, Queensland

Health Workforce Australia, through its Workforce Innovation and Reform group, undertook national consultation and development of a national health leadership framework, Health LEADS Australia (HLA) (HWA, 2013). Only one year later however, in 2014, the agency was ‘disestablished’, leaving the HLA with no institutional ‘home’ and in danger of neglect (Sebastian et. al., 2014).

In mid-2015, however, a new higher education text emerged, built around the HLA and providing a broad range of case studies, associated literature and resulting in a significant new resource to the task of building competent health service managers in Australasia (Day & Leggat, 2015). Other academic teaching, learning and research also continued to explore and develop the HLA in theory and practice (Shannon, 2015). In this way HLA became included in the selection of leadership frameworks to be explored within the university system.

The HLA was not solely in the hands of one, however. In August 2015, the Healthcare Leadership Unit, within the Health Innovation and Research Branch, Clinical Excellence Division, of the Queensland Department of Health, engaged with other jurisdictions across Australia to establish a National Leadership Collaborative. As health departments around Australia have continued to explore the implementation and evaluation of the HLA, the Collaborative has provided ongoing dialogue between peers. Currently the Collaborative is seeking to formalise the group membership by establishing a subcommittee on the topic of leadership, under the auspice of a national health workforce committee.

The Healthcare Leadership Unit also took the initiative to develop a 360 degree multi-rater feedback tool based on the capabilities identified in the Health LEADS Framework. This feedback tool is now an important component of two transformational leadership programs currently being offered by HLU and is also available for broader use across the health system. Engagement in the 360 degree feedback process includes capability assessment by means of an online survey, which can be completed anonymously by raters or alternatively, where participants are part of a leadership program, raters and participants can engage in constructive face-to-face conversation and undertake the assessment process together. This highly innovative approach is proving very effective.

This paper provides an overview of the ‘adventures of HLA’ and seeks to stimulate further discussion on the future use of the framework.

References
Synergy on employability skills for HSM
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To build competent health service managers in Australasia firstly their skill requirements must be identified. The Australian Employability Skills (ES) Framework (2012) acknowledged ES as skills and knowledge that enable employees to perform effectively in the workforce and apply technical or discipline specific skills. While industry generally appears satisfied with discipline-specific skills, ES appear under-developed. Also the contextual nature of ES has long been recognised i.e. development of ES profiles for particular types/sectors of employment. It is further known that generic ES seem more useful than job-specific skills (Liang, Short & Brown, 2006) for coping with rapidly changing and complex work environments such as in the health field. Survey of recent graduates has occurred but not for HSM, and views of employers. The aim of this paper is to make HSM requirements more visible, using feedback from senior health managers and recent graduates. The study is a secondary analysis of data already published. ES skills were found more important than discipline specific skills. The limitation in recent graduates’ ability to self-assess and the use of a convenience sample is acknowledged, but where synergy in perceptions was found it lent some weight to the conclusions. Although good agreement on importance of various competencies was achieved, skill gaps identified by the two groups were more varied. Findings can be used in curriculum development, ongoing professional development and as feedback for ACHSM capability frameworks.

References
Ibid
The National Leadership and Management Competency Framework – what it means?
Zhanming Liang & MCAP Team

The Management Competency Assessment Project (MCAP) developed a management competency framework and an evidence-based competency assessment tool (MCAP Tool) to guide assessing the competency gaps and training and development needs of health service managers in Victoria. A study is currently undertaken in partnerships with various healthcare organisations to confirm whether the Framework developed in Victoria is applicable to other Australian States and New Zealand. The confirmation will lead to the development of a National Leadership and Management Competency Framework that can guide the development of training and professional development programs for health service management workforce in Australasia.

The presentation will present the findings of the confirmation study and encourage discussions around the application and implication of the National Framework. In addition, the MCAP team is currently expanding its study to other Asia Pacific countries and would like to take the opportunities to update colleagues on the recent development hoping to further broaden the partnerships.

Learnings from simulating patient flow through an Intensive Care Unit
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The application of modelling to help understand and improve services and production is not new and has been successfully used in many industries. Such work can be traced back to the development of operations research during World War II.

Many texts describe the use of simulation modelling in service industries, such as banks and retail shops, to reduce the time spent in queues. While it is recognised that patients and health care professionals must negotiate various queues within health services, the uptake of such modelling, and especially simulation modelling, however, has not been as widely adopted in the health sector.

The UK Cumberland Initiative, an academic and industry collaboration that advocates and provides systems thinking and simulation suggests that the transformation of “the quality of care through process and system redesign will produce much higher quality outcomes and cost savings compared with the more traditional incremental improvement exercises, new drugs or better technology – and can deliver this much faster” (The Cumberland Initiative, 2016).

Recent improvements in access to software packages, such as R, an open access statistical computing and graphics package, and AnyLogic, a commercial multi-method simulation package have reduced the entry barriers for the conduct of such modelling in health.

A research project has been undertaken at the Royal Adelaide Hospital’s Intensive Care Unit to develop a patient flow simulation model in order to achieve meaningful outcomes for the Intensive Care Unit and more widely demonstrate the value of such modelling. The research is funded through the SA Premier’s International Research Fund. The international partners for the grant are the UK Cumberland Initiative and the AnyLogic Company.

The findings from the research include: observations about how some typical assumptions in queueing theory do not necessarily apply to the health sector; and learnings regarding the flow of patients in the Intensive Care Unit. The implications from these findings will be presented, along with the ramifications for health care managers and health care management teaching.

Occupational violence and Paramedics: An inductive systems approach to interactions
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Ambulance Victoria’s workforce experienced unacceptable levels of dissatisfaction and disengagement, workplace fatigue, injury and violence, which impact on their health and wellbeing. Advice from the Coroners Prevention Unit reported that the rate of suicide among paramedics is four times higher than the average rate among employed Victorians, and almost three times higher than other health and emergency service workers. The exact relevance of workplace-specific factors is as yet unknown (The VAGO, 2015).

Due to underfunding in allied health research (Rafferty et al. 2003) little is known about the specific conditions associated with the wellbeing of ambulance paramedics. Workplace aggression (including acts of bullying and violence) is an issue affecting the health care industry (e.g., Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008; Rintoul, Wynaden, & McGowan, 2009; Stubbs & Sengupta, 2008). The literature on workplace aggression has focused on groups considered at high risk such as nursing (e.g., Farrell, Bobrowski, & Bobrowski, 2006; Jackson, & Wilkes, 2005). Few studies specifically investigate the incidence of workplace aggression among allied Health professionals (Zapf, Escartín, Einarsen, Hoel, & Vartia, 2011).

Paramedics have extremely high rates of occupational violence (OV). In 2013-2014 there were 3,774 occurrences of patient or bystander aggression recorded in patient information records, although only 314 of these incidents were reported through the occupational health and safety system of Ambulance Victoria (VAGO, 2015). With the unusual nature of paramedic work and high number of OV incidents, the aim of this project is to address the lack of research on workplace aggression experienced by ambulance paramedics, with the strategic aim to better manage paramedics specific needs and to increase training and education protocols to reduce paramedic OV rates.

Method: Inductive, qualitative research was conducted employing semi-structured interviews following the process of convergent interviewing (see Dick 1990). The convergent interviews employed appropriate validity checks especially with, for example, every round of interviews comparing the records of the interviews in order to reflect the developing construction underpinning the credibility criterion (Guba & Lincoln, 1989).

Findings: This study has derived a model of the drivers of occupational violence among paramedics that reflects an interconnected system across levels from industry issues to organisational issues, the paramedic, especially their skills, and the interaction itself. The results could particularly inform both primary and secondary interventions (per Tetrick et al., 2005). In the short term the results indicate that training programs may have a large impact, although in the medium term enhancing the value-added capability of the information systems and call centre activities (e.g., demand management, enhancements to call-out information) could make further, cumulative, improvements.
From implementation theory to changed practice: The road to a “new normal” travelled by implementation savvy health service managers
Anneke Fitzgerald, Gaery Barbery & Kathryn Hayes, Griffith Business School, Gold Coast Campus, Southport

The transfer of research findings into practice has been unpredictable, haphazard and slow (Glasgow et al., 2012; Peters, Tran, & Adam, 2015; Rubenstein & Pugh, 2006). In addition to the lengthy time it takes to operationalise evidence based research, organisations often fail to fully implement the interventions they aim to adopt (Rycroft-Malone et al., 2012) or see the anticipated benefits (Parry, Carson-Stevens, Luff, McPherson, & Goldmann, 2013). This is not necessarily due to any failure of the intervention itself, rather, as evidence indicates, the most important factor influencing the underutilisation of interventions and their intended and desired outcomes is implementation failure (Aarons, Hurlburt, & Horwitz, 2011; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004).

Implementation research aims to overcome the research-to-practice gap through the scientific study of processes used in the implementation of interventions and the consideration of contextual factors that affect these processes. Much is written about implementation frameworks and dissemination techniques, but less is known about how individual operators normalise new routines (May et al., 2009). Operationalising new routines requires competent health service managers with specific skill sets, including the ability to reflect on the “why”, “how” and “what” of managing and implementing incremental practice change and disruptive innovations.

This presentation will first introduce implementation research and its importance in bridging the research-to-practice gap. It will address current diffusion of innovation in healthcare theory (Greenhalgh et al, 2004) as well as discuss the issues around marketing new ideas to stakeholders. It will then introduce a developing theory “Normalization Process Theory” (NPT) (May & Finch, 2009), which is aimed at predicting and explaining how an intervention is normalised, once the decision to adopt an intervention is made.

References
Understanding the reasons behind less than expected health professionals engagement in quality
Marie Dickinson, Christine Duffield & Jennifer Bichel-Findlay, University of Technology, Sydney

Healthcare organisations have committed resources to improve the quality of care provided, but has not realised the expected gains (Powell & Davies 2012). There is evidence within the literature that engagement of health professionals in quality is far from optimal (Davies, Powell & Rushmer 2007). Reasons provided by health professionals for a lack of engagement are primarily reported to be the lack of time and resources to support participation (Price, Fitzgerald & Kinsman 2007; Rosenstein et al. 2008). Lack of time, a commonly reported barrier, may be multiple issues affecting the health workforce and could include other reported barriers within the literature (Harding et al. 2014). Other barriers to engagement which have been identified within the literature include: lack of leadership; resistance to change; “sacred cows” (things not to be touched); lack of training; lack of accountability; role ambiguity; poor data integrity; and conflict between care giver role and management targets (Bundy et al. 2014; Davis et al. 2014; Heiwe et al. 2011). This paper will provide an overview of the barriers or facilitators found in the literature that may impact on clinicians’ willingness to engage in quality exercises.

References
Introduction: Almost a decade ago, Indonesia began its patient safety movement. Since 2011, the implementation of patient safety programs, including patient safety incident reporting, has become compulsory for all Indonesian hospitals, for accreditation and quality improvement purposes. Ideally, all Indonesian hospitals should report their incidents to the Indonesian Hospital Patient Safety Committee (IHPSC). However, according to the IHPSC’s Annual Report for 2011, only 132 incidents were reported by 132 hospitals. Since there are 2,267 hospitals in Indonesia (MOH, 2013), fewer than 6% of the total number participated in reporting.

The purpose: The purposes of this research are to analyse how the Indonesian hospitals implemented patient safety reporting as envisioned by Indonesian government; have the Indonesian hospitals adopted the WHO’s successful patient safety reporting criteria and analysing the barriers in reporting incident.

Method: Mixed methods, an approach which combines both qualitative and quantitative methods, were employed in this study. For the quantitative data, three public hospitals were selected from three different regional areas or cities in the East Java province. A pen and paper survey involved around 1,121 health workers to measure their knowledge, attitude, barriers and practice of reporting incidents. Qualitative semi-structured interviews were conducted with 32 key informants from 16 different organizations, categorized into hospitals, government organizations, independent institutions, and professional organizations. The research covered the district, provincial and national level.

Analysis: The quantitative data were analysed using cross-tabulation and Chi-square analysis. The qualitative data were analysed using Nvivo and thematic analysis.

Findings: The survey revealed significant differences between the group that “have seen an incident but did not report” and the group that “have seen incident and reported”, such as on the demographics (professions, quality and safety training), and on some of knowledge, attitude, cultural and practical barriers. Some problems on the implementation of patient safety program were revealed from the interviews, such as: the barriers to reporting incidents in the district level; that the Indonesian incident reporting system have not fully adopted the WHO’s characteristic of successful patient safety reporting system and the fact that some organizations (such as District Health Office and Provincial Health Office) have not optimized their roles in the implementation of patient safety program. There is an opportunity to involve the professional organizations such as Indonesian Medical Doctor Association and Indonesian Nurse Association by giving feedback to the organization so they could develop training to improve the health workers’ knowledge and skills on reporting incidents.
Quality systems 101: Implications for postgraduate education
Sandra Leggat & Cathy Balding, La Trobe University

This paper reports on a longitudinal research programs exploring the impact of the quality systems on the quality of care provided within eight Victorian hospitals. A systematic literature review completed for the project identified key aspects of effective quality systems as comprising consumer participation, organisational planning and leadership, ensuring an effective workforce and operational quality requirements of process management, quality consultants, reporting, analysis and benchmarking, and feedback. The findings from interviews and focus groups with over 350 managers and staff of the participating hospitals highlighted that few of the hospitals had the necessary components in place. Qualitative themes included comfort seeking instead of problem sensing behaviours, an absence of measurable quality goals and a large gap between the aspirations of boards and senior managers and the impact of the quality system in improving quality of care at point of care delivery. Based on these findings, the authors suggest essential components of quality management education for health service managers.

Consumer participation and public reporting of quality of care in hospitals
Charissa Zaga & Sandra Leggat, La Trobe University

Quality and safety in healthcare and its regular measurement and improvement continues to be a key priority for healthcare organisations around the globe. Measurement methods such as accreditation, and improvement methods such as quality improvement initiatives and the quality improvement science movement, endeavour to meet the overall aim of excellent health outcomes for patients and the minimisation of risk. Accreditation, risk reduction and quality improvement activities within health services have been well established globally since the 1970’s (Greenfield & Braithwaite, 2008). In Australia, accreditation was first implemented by acute care services in 1974, lead by the Australian Council on Healthcare Standards (Fairbrother & Gleeson, 2000). Since 2001, the Victorian Department of Health, Australia has made it a state-wide requirement for all public health services, hospitals and registered community health services to produce an annual quality of care report. This annual quality of care report aims to create a level of accountability to the Department of Health regarding quality and safety healthcare standards, policies and guidelines and to enable greater communication with the general community about these matters (Department of Health, Victoria, 2013). Since the 1978 World Health Organisation’s Declaration of Alma Ata which outlined people’s "right and duty to participate individually and collectively in the planning and implementation of their health care", bodies responsible for quality and safety in healthcare and accreditation standards have incorporated this right as a key priority. There is now growing evidence that engaging with consumers improves health outcomes, increases accessibility and appropriateness of healthcare (Australian Commission on Safety and Quality in Health Care, 2012). As such, The Australian Commission on Safety and Quality in Health Care incorporated a consumer focus within the National Standards including the EQuIP5 Standards in 2010 (Australian Commission on Safety and Quality in Healthcare, 2010) and from 2012, this was further expanded upon, with the development of the 'Partnering with Consumers' stand-alone health standard within accreditation and quality of care requirements (Australian Commission on Safety and Quality in Health Care, 2012). The quality of care reports of nine public metropolitan Victorian health services before and after the introduction of the 'Partnering with Consumers’ national standard were analysed to determine if there is a relationship between consumer participation and the public reporting of quality and safety data to consumers and communities. Public reporting by definition can be seen inherently as a medium of consumer engagement, however it acts in a linear fashion, whereby the health care setting communicates specific messages with the consumer. The contents of the quality of care reports and specifically what is selected to be reported to the public is a matter of interest in this presentation.
References