Occasional Paper: Strengthening Clinical Governance for Health Service Boards
This work draws on research undertaken as collaboration between VMIA, The Centre for Health Policy, University of Melbourne, The Department of Health and Human Services, Victoria, The Victorian Public Sector Commission and Victorian Healthcare Association.


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In 2015, little has changed since the 1995 *Quality in Australian Healthcare Study* showed one in ten admissions is associated with an adverse event, of which around half could be considered preventable. The case for managing clinical risk with as much attention as compliance, fiscal and legal considerations is one that can be measured in very real, human terms.

Research\(^1\) has highlighted the variance in board performance in governing safety and quality of care, while at the same time acknowledging the valuable role boards play in influencing their organisation’s performance in this area.

Boards can take a number of actions to strengthen engagement and reduce the restraints on performance.

**Five key areas for improvement:**

1. Integrate quality and safety governance with risk management;
2. Understand and influence patient safety culture;
3. Address gaps in board skills and knowledge;
4. Strengthen consumer engagement; and
5. Improve availability of internal and comparative quality benchmarks.

Other actions can be tailored around the board’s existing level of performance and engagement – for example highly engaged boards may consider connecting with and supporting other boards to overcome challenges they have successfully addressed.

**1. Integrate quality and safety governance with risk management**

Given its importance and strategic nature, risk management requires a strong and sustained commitment by health service boards. Clinical risks have operational, legal, political and financial dimensions and boards need robust processes for identifying, analysing, and addressing these risks as part of an integrated risk management framework.

**2. Understand and influence patient safety culture**

As healthcare organisations strive to improve, there is a growing recognition of the importance of an internal patient safety culture. Achieving a culture of patient safety requires shaping the values, beliefs, and norms about what is important and what attitudes and behaviours related to patient safety are expected and appropriate.

Achieving a change in culture first requires an understanding of the existing culture within the service, and its contributing factors and impacts, before change can be instigated. The culture of an organisation should be set by the board, modelled by management, and implemented throughout the organisation.

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3. Address gaps in board skills and knowledge

Skills and knowledge are vital to convert good intentions into practice. Training on quality, safety, and clinical governance should be a core component of board education, and should equip board members with a clear understanding of the board's role in this area and develop a suite of skills to influence change.

Training should be tailored to the needs of specific board members, and may include an induction for new board members, sessions on topical issues, and for boards who are well-advanced in this area, master classes on emerging evidence. In the case of rural health services, the potential value of distance learning should also be considered.

4. Strengthen consumer engagement

High functioning health service boards help to ensure that consumers – health service users, carers and citizens – are actively involved in shaping the health care system and making decisions about their health. The effective and meaningful engagement of patients has been shown to improve safety, quality and efficiency across a range of clinical areas.

To be effective in this area, boards need to actively seek consumer input through surveys, patient-identified data, trends, complaint investigation, board member ‘walk arounds’ of the service, and inviting consumers and staff to share their care experiences at board meetings.

5. Improve availability of internal and comparative quality benchmarks

Accurate information allows boards to effectively direct improvement efforts, and assess whether interventions have been effective. Indicators need to map performance of services over time, and ideally benchmark that performance against other providers. Board members need to understand what these indicators are, and be assured that they are being used effectively.

Improvements can be made by strengthening internal reporting frameworks, contributing to and obtaining external comparator data, and collaborating with other boards to promote best practice and reduce inefficiencies.
Background

The quality of care provided by a health service is, first and foremost, a responsibility of the organisation under the leadership of its board. So why do failures in governance continue to harm patients?

Good intentions and commitment alone are not sufficient to improve the governance of quality, safety and clinical risk. Not all board members are accountants, yet all need a competent understanding of financial drivers, reporting, and risks. Similarly, members of health service boards need not be clinicians or quality improvement experts, but they do need a sound understanding of patient safety, measures of quality, and current approaches to quality improvement.

In addition, board members need to understand they play a critical role in developing and maintaining organisational culture. Through what they say and do, board members send important signals about the issues that their health service should see as priorities. A key accountability for health service boards extends to their leadership and culture-building role – and board performance will be increasingly measured by how they perform in this space.

Key questions for director discussion:

- What is the role of the board and what are our key accountabilities?
- What are our key challenges for the next two years?
- Do we promote a culture of caring and empathy?
- How do we know our risk management framework is working effectively?
- How do we determine the information we receive is the right information?

The resources provided in this paper are intended to assist boards in becoming more active and engaged in delivering high standards of patient-centred care and fulfilling their governance role.
Understanding competing forces

Responsibility for providing high-quality care has traditionally rested with clinical leaders and hospital managers; while governing boards in the health sector focused on operations and financial stability.

The past 25 years has seen a number of driving forces cause healthcare boards to re-evaluate their responsibility in relation to the governance of quality and safety of care.

Diagram 1: Force-field model of change in clinical governance.

Driving forces

**Patient safety movement:** There is little evidence to suggest that anything has changed since the 1995 *Quality in Australian Healthcare Study* caused shockwaves with findings that one in ten admissions is associated with an adverse event, and around half are considered preventable. Nevertheless, there is a growing recognition that managing clinical risks requires as much attention as compliance, fiscal and legal concerns.

**Consumer engagement:** Consumers are more aware of their right to participate in shared decision making and to receive safe and appropriate care. Health services that cause preventable harm face significant reputational risk, loss of community confidence and declining staff culture.
Scrutiny of the role of boards in risk management: Following the global financial crisis, poor governance has been identified as a causal or contributory factor to a number of institutional failures. Local and international court cases show that boards cannot simply plead ignorance on risk management issues. Board appointments are now more highly scrutinised and board members are held to higher standards.

Regulatory requirements: There is a growing consensus that board responsibilities extend to governing all domains of organisational activity, including safety and quality. This has been mirrored at all levels of the regulatory pyramid from local education initiatives to influential inquiries and legal decisions.

Evidence of board influence: Although debate continues as to whether boards can have a measurable impact on organisational outcomes, an emerging body of international evidence suggests hospitals with boards that are actively engaged in quality issues are more likely to have quality improvement programs in place, and perform better on indicators such as risk adjusted mortality.

Restraining forces
If most health services boards are eager to prioritise governance of quality and safety of care, what is holding them back?

Gaps in board composition: To be effective in governance of quality and safety, board members need adequate skills and training. Recent research showed that although the majority of board members believed their board had expertise in this area, there were significant signs of knowledge limitation – for example, a lack of awareness of key national documents about safety and quality. Only 53% of boards provided members with training on specific quality related issues.

Paucity of benchmarks: Boards rely on useful information to exercise optimal governance, however only 50% measured quality against external benchmarks, and nearly one third did not monitor quality through simplified composite sets of indicators (for example through dashboards or scorecards).

Limited sharing: Research findings suggest that many boards in Victoria operate in relative isolation from each other. Despite many boards developing and using effective tools, templates, resources and training programs, these are not readily shared. This not only prevents dissemination of progress drivers but also creates inefficiencies through duplication of time and resources in development.

Resource demands: Board members identified fiscal challenges as barriers to effective governance of safety and quality. Larger health services (measured by total budget and inpatient separations) typically had higher levels of board engagement with quality-related activities, likely due to different patterns of relative resource availability in larger services.
Managing competing forces

Research suggests that despite these driving factors, there is a wide variance in the performance of boards in governing safety and quality of care.

Boards are engaged in an impressive array of clinical governance activities and believe they have substantial opportunities to influence quality and safety. In practice there is a wide variation in practices and there are very different levels of board progress on the ‘journey’ towards strong clinical governance.

Broadly speaking, boards (and individual board members) could be described as being highly active or less active in undertaking governance activities related to the quality or safety of care. Boards (and individual board members) also expressed positive or negative attitudes towards the role of the board in quality and safety issues.

**Diagram 2: Attitudes and activities of boards in relation to quality and safety**

Combining these two dimensions of engagement in a two-by-two table results in four general categories that may be helpful to some boards who are seeking to better understand their own progress on the clinical governance journey.
**Active improvement focus:** These boards identified quality of care as a top priority for oversight, and were engaged in 12 out of 15 quality activities in the survey. These boards were able to identify a wide range of benefits to their organisation but were still looking for further improvement opportunities. Board members modelled the accountability, transparency and respect that they expected at all levels of the organisation.

**Passive compliance focus:** At the opposite end of the spectrum, these boards are not engaged and do not have an active program of work related to governance of quality and safety. It was rare to find a board of this type, however those that were identified were found to focus on traditional governance issues such as fiscal and compliance rather than clinical risk. On some occasions this attitude was encouraged by senior medical staff who viewed the board as ‘meddling’ in operations.

**Active compliance focus:** Boards in this quadrant were engaged in a range of clinical governance activities. However during interviews, many expressed their scepticism about the true value of board engagement in clinical governance. These boards tended to focus on compliance activities, including reporting, inspection, reviews and accreditation.

**Passive improvement focus:** This cohort includes boards that would like to play a stronger role in governing the safety and quality of care, but feel constrained to do so. While these boards would ‘ideally’ like to be more involved, they argue that the complex reality of governing health services, with limited resources and increasing demands, presents challenges – particularly in the face of other priorities such as fiscal deficits and large capital projects. Many of these boards have smaller budgets and smaller executive teams, and acknowledge the benefits of resources available in larger health services. In some cases their passive approach may be a result of a perceived lack of resources and capacity to undertake a more active governance role.
Governance as performance

A paradigm shift has occurred in the way governance itself is now viewed.

The Victorian clinical governance policy framework sets out the principles and components of effective clinical governance for Victorian health services. It stresses that the health service board has ultimate accountability for the safety and quality of clinical services, including setting expectations of all levels of the health service, creating and promoting a positive safety culture and driving performance improvement through measurement, review and benchmarking activity.

Under the *Health Services Act*, the boards of metropolitan and regional health services are required to ensure that:

- effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided.
- any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner.
- they continuously strive to improve the quality of the health services they provide and to foster innovation (Department of Health and Human Services 2013).

While the *Health Services Act* provides only broad guidance on the role of boards of smaller rural health services, in practice the expectations of these boards closely align with the requirements of their larger counterparts.

The increased onus on the accountability of boards is exemplified by changes to Victorian health service performance monitoring in recent years, where the focus on safety and quality has been emphasised and the expectations that apply to health boards has been increased.

One of the most fundamental shifts in thinking within the framework is the way that governance itself is viewed. This shift turns on the distinction between governance of performance and governance as performance: for the first time, health service boards are being overtly held to account not only for the performance results of their health service, but for the way they govern to achieve performance outcomes and performance improvement. Governance as performance means that boards are increasingly under scrutiny about the extent to which they lead continuous performance improvement and create a patient-centred culture built around safety, quality and effective clinical risk management.
Resources

The following organisations and resources provide support to boards in a healthcare setting:

- Asia Pacific Forum on Health Innovation and Improvement
- Australian Centre for Healthcare Governance
- Australian Commission on Safety and Quality in Health Care
- Australian Institute of Company Directors. Healthcare Directors Workshop
- Department of Health and Human Services
- Health Issues Centre
- National Safety and Quality Health Standards
- Rural Health Consumer Participation program
- Victorian Healthcare Experience Survey
- Victorian Managed Insurance Authority
- Victorian Public Sector Commission