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Feature

# The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria

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**Abstract**

**Objectives.** To determine the nature and extent of governance activities by health service boards in relation to quality and safety of care and to gauge the expertise and perspectives of board members in this area.

**Methods.** This study used an online and postal survey of the Board Chair, Quality Committee Chair and two randomly selected members from the boards of all 85 health services in Victoria. Seventy percent (233/332) of members surveyed responded and 96% (82/85) of boards had at least one member respond.

**Results.** Most boards had quality performance as a standing item on meeting agendas (79%) and reviewed data on medication errors and hospital-acquired infections at least quarterly (77%). Fewer boards benchmarked their service's quality performance against external comparators (50%) or offered board members formal training on quality (53%). Eighty-two percent of board members identified quality as a top priority for board oversight, yet members generally considered their boards to be a relatively minor force in shaping the quality of care. There was a positive correlation between the size of health services (total budget, inpatient separations) and their board's level of engagement in quality-related activities. Ninety percent of board members indicated that additional training in quality and safety would be 'moderately useful' or 'very useful'. Almost every respondent believed the overall quality of care their service delivered was as good as, or better than, the typical Victorian health service.

**Conclusions.** Collectively, health service boards are engaged in an impressive range of clinical governance activities. However, the extent of engagement is uneven across boards, certain knowledge deficits are evident and there was wide agreement among board members that further training in quality-related issues would be useful.

**What is known about the topic?** There is an emerging international consensus that effective board leadership is a vital element of high-quality healthcare. In Australia, new National Health Standards require all public health service boards to have a 'system of governance that actively manages patient safety and quality risks'.

**What does this paper add?** Our survey of all public health service Boards in Victoria found that, overall, boards are engaged in an impressive range of clinical governance activities. However, tensions are evident. First, whereas some boards are strongly engaged in clinical governance, others report relatively little activity. Second, despite 8 in 10 members rating quality as a top board priority, few members regarded boards as influential players in determining it. Third, although members regarded their boards as having strong expertise in quality, there were signs of knowledge limitations, including: near consensus that (additional) training would be useful; unfamiliarity with key national quality documents; and overly optimistic beliefs about quality performance.

**What are the implications for practitioners?** There is scope to improve board expertise in clinical governance through tailored training programs. Better board reporting would help to address the concern of some board members that they are drowning in data yet thirsty for meaningful information. Finally, standardised frameworks for benchmarking internal quality data against external measures would help boards to assess the performance of their own health service and identify opportunities for improvement.

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## Introduction

National health policy reforms place local governing boards at the centre of a drive toward improved quality of health care.[1] Public health service boards have been established in each state and territory and new National Health Standards require a 'system of governance that actively manages patient safety and quality

risks'.[2] These moves respond to an emerging international consensus that board leadership is a vital element of high-quality care.[3–10]

A growing body of international research suggests that hospitals with boards that are actively engaged in quality issues are more likely to have quality-improvement programs in place and to perform better on indicators such as risk-adjusted mortality rates.[9,11] Early evidence from hospital systems overseas suggests that whereas some boards perform strongly, others lack understanding of patient safety problems and receive inadequate information for sound decision making.[11] Little is known about Australian boards' engagement in clinical governance.

We surveyed members of boards of all public hospitals, public health services and multipurpose services in Victoria ('health services'). Our aims were: (1) to ascertain the nature and extent of the boards' current activities in overseeing quality; and (2) to describe the expertise and perspectives of board members in this area.

## Methods

### *Setting*

Victoria has 85 public health services, ranging from metropolitan services with more than 500 acute care beds to rural services with fewer than five beds. Sixteen health services are located in metropolitan areas; the rest are in regional and rural communities.[12] Each is overseen by a board appointed by the Minister for Health.

All boards in Victoria are required to have a quality committee, and to publish an Annual Quality of Care report.

At the time of the study, health services were preparing for the introduction of the National Safety and Quality Health Service Standards, which form the basis for accreditation of public health services from 1 January 2013.[2] These standards stipulate that boards are 'responsible for governing all organisational domains of activity including . . . safety and quality'. Standard 1 sets forth five criteria in this area (Table 1).

### *Study sample and instrument*

We sampled four members from each board: the Chair, the Chair of the Quality Committee and two other randomly selected members from among members who had served on the board for at least 12 months.

We adapted for the Australian context a survey developed by Jha and Epstein in the United States.[11] To ensure the appropriateness of the questions for the Victorian context, we sought feedback from the Victorian Department of Health, the Victorian Healthcare Association and the Victorian Managed Insurance Authority and piloted the survey with three board members and a former board Chair who were not part of the study sample.

The instrument defined 'quality' as referring to four dimensions of healthcare: appropriateness, effectiveness, acceptability and safety. It then asked respondents which quality-related activities, from a specified list of possible activities, their boards were undertaking. The activities were derived from a similar list developed by Jha and Epstein,[11] the new National Standards,[2] and a review of the international literature on clinical governance.

Survey questions also addressed four other domains: board members' training and perceived expertise; perceptions of their health service's quality performance; board priorities; and perceptions of the board's influence over quality.

The Department of Health provided data on the total annual budget and number of inpatient separations for each health service.

### *Survey administration*

A survey research company (Strategic Data) administered the survey in March 2012. Participants could complete the survey online, on paper or by telephone. Non-responders were followed up by email and telephone.

### *Analysis*

We analysed the response data by computing simple counts and cross-tabulations. We constructed a 'quality activity score'

**Table 1. Standard 1: governance for safety and quality in health service organisations[2]**

| Criterion | Suggested board-level strategies for meeting criterion[A] |
|---|---|
| There are integrated systems of governance to actively manage patient safety and quality risks | Prioritise and allocate an appropriate amount of time to reviewing clinical governance issues<br>Review a 'dashboard' of the organisation's most important quality metrics |
| Care provided by the clinical workforce is guided by current best practice | Receive information generated through audits and other sources to monitor the proportion of care that is provided in accordance with clinical guidelines or pathways<br>Ensure an effective system is in place for recording patient clinical information that enables later extraction of relevant information for quality assurance and research purposes |
| Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high-quality healthcare | Adopt an organisational orientation, education and training policy that clearly defines the organisation's commitment to education and training in safety and quality<br>Receive regular reports on the adequacy of workforce engagement with, and understanding of, the quality and safety system |
| Patient safety and quality incidents are recognised, reported and analysed and this information is used to improve safety systems | Consider whether the incident management system complies with best practice design principles and whether adequate resources are allocated to risk management<br>Lead implementation of effective open disclosure by adopting the national open disclosure standard or a standard that achieves an equivalent outcome |
| Patient rights are respected and their engagement in their care is supported | Receive regular reports to monitor the effectiveness of the Australian Charter of Healthcare Rights in establishing a framework for patient rights<br>Ensure that an effective system is in place for informing patients and their carers, determining patient treatment preferences and gaining their consent to treatment |

[A]Selected examples of strategies promulgated in relation to Standard 1 by the Australian Commission on Safety and Quality in Health Care.

by assigning one point for each activity a board was undertaking, from a list of 15 activities that members were specifically queried about. A score of 15 points indicated engagement in all 15 quality-related activities.

Responses to questions about expertise, knowledge and attitudes were analysed at the board member level; responses about board activities were analysed at the board level using the Chair's response if members' responses were divergent. We tested for statistically significant associations between boards' quality activity scores and their size – as measured by their total annual budget and total annual inpatient separations, respectively using Kendall's rank correlation.

All analyses were conducted using R version 2.15.1.[13] The Human Research Ethics Committee of the University of Melbourne approved the study.

## Results

### *Characteristics of respondents*

Of the 332 members surveyed, 70% (233) responded and 96% (82/85) of boards had at least one member respond. Of the three boards that declined to participate, two were in rural areas and one was in a metropolitan area.

Forty-six percent of surveyed board members served on a quality committee of the board. Respondents had an average tenure of 7 years (range 1–36 years). One-third of members had no governance experience before their appointments, and one in five board members had served on the board for 10 or more years. Table 2 describes other characteristics of the respondents.

**Table 2. Characteristics of board members ($n = 233$ members)**

| | *n* | % |
|---|---|---|
| Male | 128 | 55 |
| Tenure on board[A] | | |
| 1–3 years | 71 | 31 |
| 4–6 years | 64 | 28 |
| 7–9 years | 47 | 20 |
| 10 or more years | 50 | 22 |
| Professional background[B] | | |
| Business, finance or accounting | 106 | 46 |
| Health practitioner | 59 | 26 |
| Medicine | 16 | 7 |
| Nursing or midwifery | 16 | 7 |
| Other health practitioner | 27 | 12 |
| Education | 31 | 14 |
| Law | 18 | 8 |
| Other | 72 | 31 |
| Governance experience before appointment | | |
| None | 77 | 33 |
| <5 years on any board | 55 | 24 |
| ≥5 years on board of small or medium-sized organisation | 64 | 27 |
| ≥5 years on board of large organisation | 36 | 15 |

[A]One missing response for tenure and governance experience and four missing responses for professional background are not shown.

[B]Percentages sum to more than 100 because some respondents' professional backgrounds were in more than one field.

### *Engagement in quality-related activities*

Table 3 reports the proportion of boards undertaking each of 15 quality-related activities. A majority of boards had established quality goals (84%) and regularly monitored progress toward the board's quality of care plan (77%). By contrast, only half of boards assessed the organisation's quality against external benchmarks, just over half of boards provided members with formal training on quality-related issues and fewer than one-quarter provided members with training on healthcare disparities. The quality activity score, which is based on the sum of activities each board was undertaking, indicated substantial variation in clinical governance activities across boards (Fig. 1). For example, whereas 25 boards were engaged in less than half of the 15 specified activities, 19 boards were undertaking 12 or more of them.

The amount of time boards spent on quality of care issues also varied. Seven boards reported spending 10% or less of their time on quality of healthcare issues, whereas nine boards spent more than 30%.

There was a significant positive correlation between the quality activity score at board level and both the annual budget ($\text{tau} = 0.28$, $P < 0.0001$) and annual inpatient separations ($\text{tau} = 0.28$, $P < 0.0001$) of the health service. In other words, the boards

**Table 3. Quality-related activities undertaken by boards ($n = 82$ boards)**

ATSI, Aboriginal and Torres Strait Islander

| | *n* | % |
|---|---|---|
| Board has established or endorsed goals relating to patient outcomes | 69 | 84 |
| Quality performance is on the agenda at every board meeting | 65 | 79 |
| Board monitors progress toward quality of care plan at least quarterly | 64 | 78 |
| Board reviews data on medication errors and hospital-acquired infections at least quarterly | 63 | 77 |
| Board has requested an investigation or report on a specific quality issue in the past 3 years | 61 | 75 |
| Board uses quality data as basis for recognition/awards for clinical staff | 60 | 73 |
| Board regularly reviews a quality scorecard or dashboard | 60 | 73 |
| Board has established goals relating to staff experience or satisfaction | 50 | 61 |
| Board has a strategy relating to coordination of care after discharge | 46 | 56 |
| Board members receive formal training that covers quality of care | 43 | 52 |
| Board has a strategy relating to communication with patients and families | 42 | 51 |
| Board monitors quality and safety of care against external benchmarks | 41 | 50 |
| Board spends more than 20% of its time on quality of healthcare issues | 34 | 41 |
| Board receives quality of care data analysed according to the cultural and linguistic background of patients (including ATSI background) | 26 | 32 |
| Board members receive training on healthcare disparities | 18 | 22 |

of larger organisations were more likely to be highly engaged in the quality-related activities covered in our survey than were the boards of smaller organisations. However, this was not uniformly true: some rural boards, for example, had very high-quality activity scores whereas some metropolitan boards reported undertaking fewer than half of the specified activities.

Besides the specific activities they were queried about, some respondents mentioned other quality-related activities in which their board was engaged, including annual quality of care retreats, regular literature reviews, public forums, partnerships with indigenous communities, presentations by patients and families, leadership walk-arounds and quality of care awards.

### *Perceived expertise and knowledge*

Ninety percent (208/233) of board members believed that their board had 'moderate' or 'very significant' expertise in quality of care issues. Nearly two-thirds (138/231) said that expertise in quality of care issues was important when recommending new board appointees. Nonetheless, 90% of board members (218/233) indicated that additional training would be 'moderately useful' or 'very useful'.

Board members' familiarity with key quality-related policies, indicators and standards was uneven. Most members were familiar with major Victorian documents, including the Department of Health's Quality of Care Report guidelines[14] (94% of members 'somewhat familiar' or 'very familiar') and the Patient Satisfaction Monitor[15] (91%). There was less familiarity with major national documents: 46% of members were 'not familiar' with the Open Disclosure Standard[16] and 37% were 'not familiar' with the Australian Charter of Healthcare Rights.[17]

Members of quality committees were more closely familiar with Quality of Care Report guidelines than other board members (52% *v.* 33% 'very familiar', $P = 0.003$), but not with the Open Disclosure Standard or the Charter.

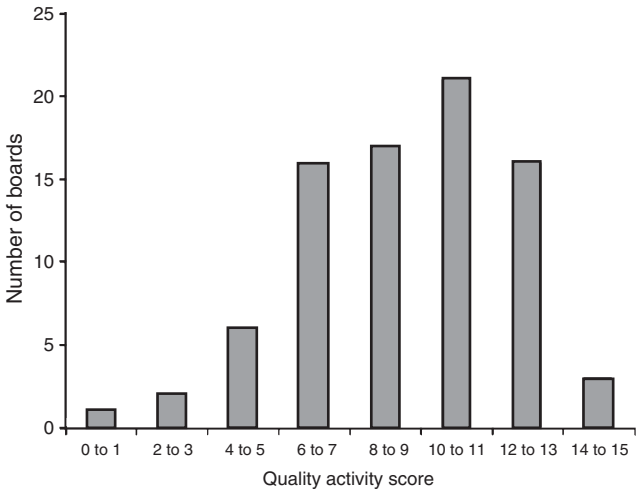


**Fig. 1.** Distribution of boards by total number of quality-related activities they were engaged in, from among a specified list of 15 activities.

### *Board priorities and influence*

From a list of six possible priorities for board oversight including financial performance, business strategy and operations – most members (82%) identified quality of care as one of the top two priorities. Yet members generally considered their boards to be a relatively minor force in shaping the quality of care. Less than 10% of members named the board or the board chair as the first or second most influential actor in determining quality, although 21% named the board's Quality Committee (Fig. 2). Members rated the Chief Executive Officer to be the most influential actor, followed by the Director of Nursing.

### *Perceived performance*

Almost every respondent (225/231) believed the overall quality of care delivered by their health service was the same or better than the typical Victorian health service. None rated it as worse, although six members said they did not know how their health service compared and a small fraction (<1%) rated it as worse

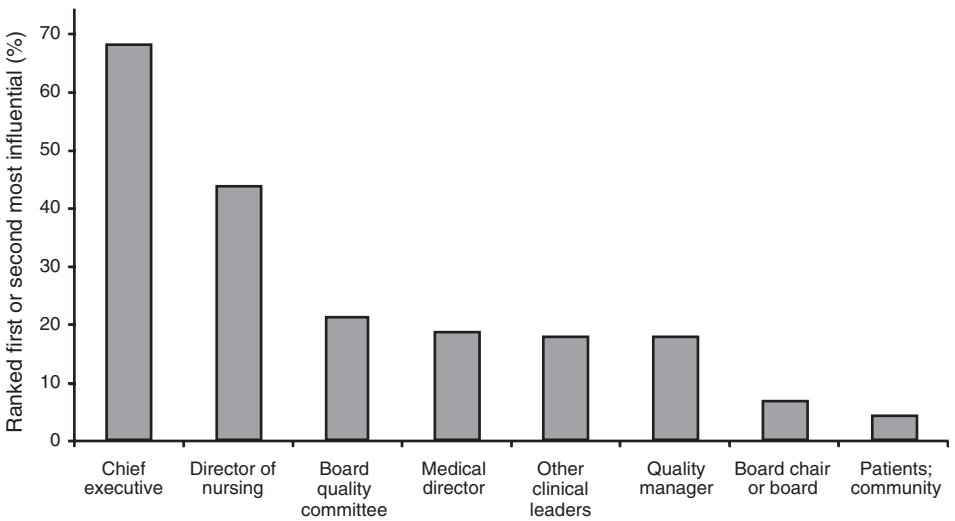


**Fig. 2.** Perceptions of board members regarding who most influences quality of healthcare.

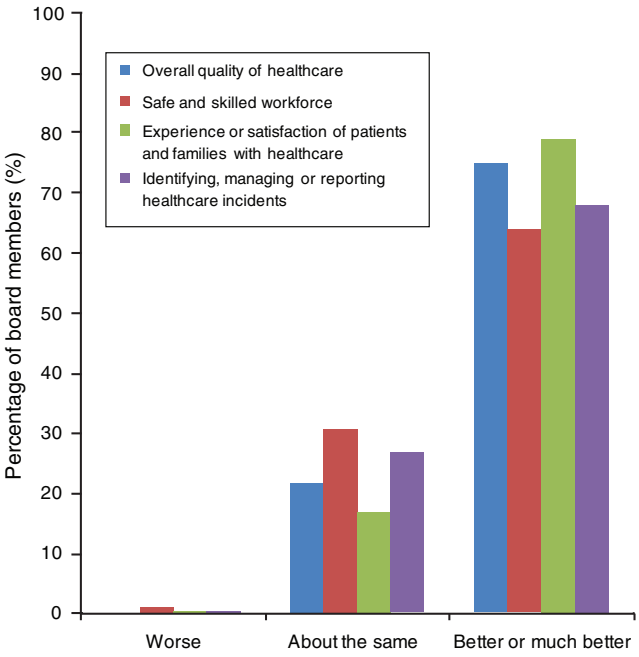


**Fig. 3.** Board members' perception of the quality of their health service compared with the typical Victorian health service. Numbers add to less than 100% because some respondents (<5%) selected 'didn't know' in response to questions about how their health service compared with others.

on particular dimensions of performance (e.g. having a safe and skilled workforce) (Fig. 3).

## Discussion

Overall, Victorian health service boards were engaged in an impressive range of clinical governance activities. However, tensions were evident. First, whereas some boards appeared to be strongly engaged in quality-related activities, others reported relatively little activity. Organisational size was positively correlated with intensity of engagement. Second, despite 8 in 10 members rating quality as a top board priority, few members regarded boards as an influential player in determining it. Third, although members regarded their boards as having strong expertise in quality, there were signs of knowledge limitations, including: wide agreement that (additional) training in this area would be useful; unfamiliarity with key national quality documents; and overly optimistic beliefs about quality performance.

Our findings highlight four inter-related challenges for clinical governance by health service boards in Victoria. First, for boards to become active and enthusiastic about quality governance two elements seem essential: (1) a belief that this is a core part of their mission; and (2) confidence that doing so will drive better outcomes for patients. Our findings suggest that boards have embraced the first element but not the second. Board members felt that they played a relatively modest role in influencing quality, rating their contribution well below that of senior management and clinical leaders.

Second, there is scope to improve boards' understanding of quality issues. Nearly half of the boards did not offer formal training in this area, and members signalled a strong appetite for it. This finding resonates with results from a 2000 survey of 47 Australian hospital board chairs, which suggested underinvestment in professional development of board members.[18] Further qualitative research is needed to understand the nature and form that such training should take for optimum impact. Options include in-house training by staff with expertise in this area, the expansion of tailored programs offered by organisations such as the Australian Centre for Healthcare Governance, or the addition of a clinical governance module to the governance training offered by the Australian Institute of Company Directors. Third, our survey pointed to several gaps in measurement. An oft-quoted adage in management circles is that 'you can't manage what you don't measure'. Nearly one-third of the boards did not monitor quality through simplified composite sets of quality indicators, such as dashboards and scorecards.[19] Lack of effective reporting structures is a recurring theme in inquiries into quality breakdowns in healthcare institutions.[20] Finally, half of the boards did not routinely compare internal quality data against external measures. The absence of standardised frameworks for making such comparisons is likely to be a retarding factor here.[21] Although the Department of Health collects volumes of data from health services, few outcome measures are consistently made available to health services to support benchmarking activities in the field (Bismark MM, Studdert DS unpub. data). Some health services have taken the initiative, entering into data-sharing collaborations with peers (e.g. through the Health Roundtable[22]), but the benefits of such initiatives are confined to member organisations. The lack of benchmarking may go some way toward explaining the uniform belief among respondents that the quality of care delivered by their health service was as good as or better than others. Jha and Epstein[11] found similar overoptimism among hospital board chairs in the USA, and the same kind of misperceptions have been observed in other studies of performance self-assessments by drivers, students, educators and others.[23,24] A recognised cause of these so-called 'Lake Wobegon effects' (named after Garrison Keillor's fictional community, in which 'all the women are strong, all the men are good looking, all the children are above average') is unavailability or underuse of reliable information on peer performance.

Our study has limitations. The generalisability of our findings outside Victoria is unknown. However, because the new national governance framework borrowed heavily from Victoria's model, our findings have relevance for boards elsewhere. Additionally, we relied on self-reported measures of knowledge and performance. Despite assurances of anonymity, a degree of social desirability bias is likely and its effect would be an inflated picture of activity and engagement. Finally, our study is descriptive: it provides a valuable snapshot of board members' attitudes and activities in this area. Further work is required to understand whether a causal relationship exists between effective clinical governance and improved patient outcomes in public health services.

Historically, health service boards focussed on financial issues and chief executive performance.[25] Quality of care was assumed, its oversight was left to clinical leaders and it tended to be poorly measured.[26] That approach is being rewritten today, spurred by mounting evidence that organisational factors, including high-level leadership, influence quality of care.[7,9,11,27] Findings from the present study point to several steps that may assist health

service boards in Australia to enhance the depth and value of their contributions to ensuring that patients receive better care.

## Competing interests

The authors declare there are no competing interests.

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