The Director’s Toolkit

A resource for Victorian health service boards
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About this Toolkit

This Toolkit is a resource to assist public health service board directors and other interested parties to better understand the role of directors of health service boards and the operating environment of the public sector health service entities they govern.

The development of the Toolkit is in response to DHHS recognising the need for a stronger emphasis on public sector health governance and enhancing the support tools available to directors of health services. Recent reports such as the ‘Targeting Zero’ review of quality and safety in the Victorian public health service have highlighted the need for greater oversight of clinical care systems across the state in the delivery of high quality, safe, person-centred care.

This accountability starts with the board.

The board of directors is held to be ultimately responsible for virtually every aspect of the health service’s activities. However, it is impractical and undesirable for a board to attempt to supervise minutia associated with the health service’s operation.

Good corporate governance requires a balance between compliance (with codes, regulations and standards) and oversight of operational and financial performance. The core purpose of good governance in health services is ensuring the delivery of high quality, safe and effective person-centred care.

Boards of high performing health services:

- understand the board’s role in governance
- discharge their legal duties
- ensure accountability to stakeholders
- understand stakeholder and management expectations
- effectively use board committees to enhance governance
- build a talented management team
- champion a productive and ethical culture
- make informed decisions
- actively contribute to strategy, and closely monitor strategic effectiveness
- ensure a disciplined approach to risk governance
- receive independent assurance
- actively engage externally on current and emerging issues relevant to their organisation and the political, social, and economic environment in which it operates.

By understanding the environment and the pressures the health service and its management face, the board can assure itself that the material risks are being identified and, most importantly, being managed. Such an approach enables the board to exercise its responsibilities in an active rather than a reactive manner and minimises ‘surprises’. The board should be alert to the red flags or risk indicators that may impact the organisation’s performance.

In preparing this Toolkit, DHHS, in its stewardship role, has not attempted to establish a model or pattern for the optimum composition and conduct of a health service board and instead has provided insight and guidance as a practical resource for health service directors.

For guidance, on the initial pages of chapters 1–14, there are a number of red flags, plus a list of pertinent questions that directors of health services may ask.

In addition, the Toolkit documents and summarises information on roles and responsibilities and consolidates statutory and policy-based elements, including those in the Health Services Act 1988 (Vic), the Ambulance Services Act 1986 (Vic), the Mental Health Act 2014 (Vic), other acts, and policy and administrative documents.
Although this Toolkit sets out material of key importance to health service boards, the boards of other entities, such as, ambulance services, mental health services, aged care services, community health centres, and other private and not-for-profit entities delivering Victorian Government health services, may also find the material useful.

Historically, health service boards focussed on financial issues and chief executive performance. Quality of care was assumed, its oversight was left to clinical leaders and it tended to be poorly measured. That approach is being rewritten today, spurred by mounting evidence that organisational factors, including high-level leadership, influence quality of care.*

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full description</th>
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<tbody>
<tr>
<td>AACC</td>
<td>Aged Care Complaints Commissioner</td>
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<tr>
<td>AAQHC</td>
<td>Australasian Association for Quality in Health Care</td>
</tr>
<tr>
<td>AAS</td>
<td>Australian Accounting Standards and Interpretations</td>
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<td>AASB</td>
<td>Australian Accounting Standards Board</td>
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<td>ABF</td>
<td>Activity based funding</td>
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<td>ACAS</td>
<td>Aged Care Assessment Services</td>
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<td>AGM</td>
<td>Annual General Meeting</td>
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<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>ASA</td>
<td>Ambulance Services Act 1986 (Vic)</td>
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<td>ASIC</td>
<td>Australian Securities and Investments Commission</td>
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<tr>
<td>AV</td>
<td>Ambulance Victoria</td>
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<td>BBCAC</td>
<td>Building Board Capability Advisory Committee</td>
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<td>BCV</td>
<td>Better Care Victoria</td>
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<td>BMAC</td>
<td>Boards Ministerial Advisory Committee</td>
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<tr>
<td>CBC</td>
<td>Council of Board Chairs</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
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<tr>
<td>COO</td>
<td>Chief Operations Officer</td>
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<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DMS</td>
<td>Director of Medical Services</td>
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<tr>
<td>DPC</td>
<td>Department of Premier and Cabinet</td>
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<tr>
<td>DPI</td>
<td>Declaration of Private Interests</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Groups</td>
</tr>
<tr>
<td>DSM-V</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 5th revision. This the manual used primarily in the USA (but also widely used in Australia in addition</td>
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<tr>
<td>Acronym</td>
<td>Full description</td>
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<tr>
<td>Acronym</td>
<td>Full description</td>
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<tr>
<td>ICD-10</td>
<td>International Statistical Classification of Diseases and Related Health Problems, 10th Revision. This is the disease classification used in Australia cf. DSM-V</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>- a CM suffix refers to Clinical Modification</td>
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<tr>
<td>- an AM suffix refers to Australian Modification</td>
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<tr>
<td>- a different number instead of 10 will refer to a different revision e.g. 9th revision</td>
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<tr>
<td>KPI</td>
<td>Key performance indicator</td>
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<tr>
<td>LHN</td>
<td>Local hospital network</td>
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<tr>
<td>LOS</td>
<td>Length of Stay</td>
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<td>LTI</td>
<td>Lost Time Injury</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act 2014 (Vic)</td>
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<tr>
<td>MHCC</td>
<td>Mental Health Complaints Commissioner</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi Purpose Service</td>
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<tr>
<td>NAESG</td>
<td>Non Admitted Emergency Services Grant</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NEP</td>
<td>National Efficient Price (as determined by IHPA)</td>
</tr>
<tr>
<td>NSQHS Standards</td>
<td>National Safety and Quality Health Service Standards</td>
</tr>
</tbody>
</table>

DTF | Department of Treasury and Finance |
FMA | *Financial Management Act 1994 (Vic)* |
GiC | Governor in Council |
GSERP | Government Sector Executive Remuneration Panel |
HCC | Health Complaints Commissioner |
HMI | Hospital Mortality Indicator |
HPV | Health Purchasing Victoria |
HSA | *Health Services Act 1988 (Vic)* |
HSMR | Hospital Standardised Mortality Ratios |
IBAC | Independent Broad-based and Anti-Corruption Commission |
IHPA | Independent Hospital Pricing Authority |
ICD-10 | a CM suffix refers to Clinical Modification |
| an AM suffix refers to Australian Modification |
| a different number instead of 10 will refer to a different revision e.g. 9th revision |

Note:

- a CM suffix refers to Clinical Modification
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- a different number instead of 10 will refer to a different revision e.g. 9th revision

Acronyms and definitions/ 7
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full description</th>
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<tr>
<td>NWAU</td>
<td>National Weighted Activity Unit against which NEP is paid (national equivalent of WIES)</td>
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<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
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<tr>
<td>OHSA</td>
<td>Occupational Health and Safety Act 2004 (Vic)</td>
</tr>
<tr>
<td>OVA</td>
<td>Occupational Violence and Aggression</td>
</tr>
<tr>
<td>PAA</td>
<td>Public Administration Act 2004 (Vic)</td>
</tr>
<tr>
<td>PDA</td>
<td>Protected Disclosures Act 2012 (Vic)</td>
</tr>
<tr>
<td>PFG</td>
<td>Policy and Funding Guidelines (updated every year)</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Monitoring Framework</td>
</tr>
<tr>
<td>PRISM</td>
<td>Program Report for Integrated Service Monitoring</td>
</tr>
<tr>
<td>PSRACS</td>
<td>Public Sector Residential Aged Care Services</td>
</tr>
<tr>
<td>SCV</td>
<td>Safer Care Victoria</td>
</tr>
<tr>
<td>SoP</td>
<td>Statement of Priorities</td>
</tr>
<tr>
<td>SRHS</td>
<td>Small Rural Health Services</td>
</tr>
<tr>
<td>TRP</td>
<td>Total remuneration package (for an executive salary)</td>
</tr>
<tr>
<td>VAGO</td>
<td>Victorian Auditor General’s Office</td>
</tr>
<tr>
<td>VAHI</td>
<td>Victorian Agency for Health Information</td>
</tr>
<tr>
<td>VCC</td>
<td>Victorian Clinical Council</td>
</tr>
<tr>
<td>VGRMF</td>
<td>Victorian Government Risk Management Framework</td>
</tr>
<tr>
<td>VHA</td>
<td>Victorian Healthcare Association</td>
</tr>
<tr>
<td>VIFMH</td>
<td>Victorian Institute of Forensic Mental Health, also known as ‘Forensicare’</td>
</tr>
<tr>
<td>VMIA</td>
<td>Victorian Managed Insurance Authority</td>
</tr>
<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
</tr>
<tr>
<td>VPSC</td>
<td>Victorian Public Services Commission</td>
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<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separation</td>
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</table>
### Key definitions used in this Toolkit

<table>
<thead>
<tr>
<th>Definition</th>
<th>Full description</th>
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<tbody>
<tr>
<td>Consumers</td>
<td>‘patients’ and ‘consumers’ are terms often used to describe users of health services. In this Toolkit, ‘consumers’ has been used, unless it is part of a publication title or a quotation, as patients are not the only users of health services.</td>
</tr>
<tr>
<td>Directors</td>
<td>In this Toolkit, all board directors are referred to as directors or chairs as applicable, and the roles and responsibilities are outlined as applying to all boards.</td>
</tr>
<tr>
<td>Enabling Acts(^1)</td>
<td>Health Services Act 1988 (Vic) (HSA). Mental Health Act 2014 (Vic) (MHA). Ambulance Services Act 1986 (Vic) (ASA) (in some circumstances other acts may also be applicable). If one Enabling Act is referenced such as the HSA, the reader should presume the other Enabling Acts may also apply and should check the other Enabling Acts for clarification.</td>
</tr>
<tr>
<td>HLA Bill</td>
<td>Health Legislation Amendment (Quality and Safety) Bill 2017 was introduced into Parliament in June 2017 in response to the Targeting Zero report and the Government’s response, Better, Safer Care. This Bill amends the Enabling Acts for health services, in particular relating to obligations for board directors and the composition and conditions of appointment of boards.</td>
</tr>
<tr>
<td>HPV</td>
<td>Health Purchasing Victoria (HPV) is the organisation established to assist the Victorian health sector ease cost pressures through collective, strategic purchasing for all health services.</td>
</tr>
<tr>
<td>Minister</td>
<td>In this Toolkit, Minister refers to the Victorian Ministers for Health, Ambulance Services, and Mental Health where applicable.</td>
</tr>
<tr>
<td>Patient Experience Survey</td>
<td>Collects data from consumers of health services in Victoria and is used as a key feedback mechanism in clinical governance to identify areas for improved provision of service or management of risks. It is a critical stakeholder engagement and performance management / monitoring tool.</td>
</tr>
<tr>
<td>People Matter Survey</td>
<td>Regular survey of health service staff undertaken by health services to identify workforce engagement, participation, concerns or other feedback. It is a critical stakeholder engagement and performance management / monitoring tool.</td>
</tr>
<tr>
<td>Health services</td>
<td>The term ‘health services’ is used to refer to both the ‘public hospitals’, ‘public health services’ and multi-purpose services listed in the HSA, as well as Ambulance Victoria (ASA) and VIFMH (MHA) unless otherwise specified.</td>
</tr>
<tr>
<td>Secretary</td>
<td>The Secretary of the DHHS.</td>
</tr>
<tr>
<td>Victorian Clinical Council</td>
<td>Victorian Clinical Council is a council of clinicians and consumers whose purpose is to provide leadership and direction to make the health system safer and provide better care to all Victorians.</td>
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</tbody>
</table>

\(^1\) Please note, these acts may have been amended and/or updated after this Toolkit was published. When reviewing, please review the most recent version.
1. Victoria’s health service governance model

The Victorian health system is efficient and delivers safe, high quality services to consumers.

What underpins this performance is a high degree of organisational stability and a well understood model of governance whereby Victoria’s health services are overseen by autonomous boards that work within a state wide framework of priorities.

It is a significant privilege and responsibility to serve on a health service board within such a successful system and it is within this context the performance of board directors and their health service will be assessed.

Introduction to the chapter

This chapter will provide you with:

1.1 an overview of what health services are, why we need board directors, and an overview of the Enabling Acts

1.2 Victoria’s governance model and what ‘good governance’ means and where health services fit within these concepts

1.3 an outline of government, its major stakeholders and health service interactions with those stakeholders

1.4 the strategic context and policies that are currently impacting, or will impact, Victorian health services.
1.1 Health services and governance

Health service board directors are an integral part of Victoria’s health system.

You are leaders of the system and much is expected of you, from your expertise, your time, to your dedication in driving continual improvement and innovation. You are also expected to be highly skilled in running a complex, high risk organisation and to understand and learn the nuances and specifics of running a public entity in the Victorian governance system, all while delivering safe, high quality services.

Health services cannot operate without you, and they cannot operate safely without robust, good governance. In order for directors to deliver all that is asked of them, a strong understanding of best practice governance and governance standards is required.

Questions that directors of health services should ask

- Do I know why our health service is so important and needed by the government and community?
- Do I understand the different types of health services and the services they deliver?
- Do I understand the broader Victorian health system and the part our health service plays in it?
- How well do I understand the relevant provisions of the relevant Enabling Act?
- How well do I understand how and when these provisions apply?
- What are the goals of my health service and where does it sit within the broader health system?

Red flags

- Directors cannot identify the key pieces of legislation that support their health service.
- The board does not understand where it fits in the context of the health service.
- The board does not know who its key stakeholders are and why they are important.
- Directors are not aware of what the relevant Enabling Act contains and how it is relevant to the governance of the health service.
- There is little reference to the relevant Enabling Act in any of the induction material provide to directors.
- Directors do not understand where their health system fits in the broader system.
Why health service directors are so important

Victoria has a system of public administration which relies on thousands of public entities to deliver a range of services and functions that are essential to Victoria.

These public entities are typically overseen by a board of directors who operate independently of the State while remaining accountable to the Minister.

There are risks inherent in this type of model. Good governance is the key to help directors mitigate the many risks and challenges of being a director such as:

- functioning in increasingly challenging, increasingly complex environments
- operating in fiscally constrained spaces with pressure to minimise costs and operate more efficiently
- managing the performance of outsourced services
- working within a number of regulatory, compliance and oversight frameworks
- reporting on performance.

The board is responsible for oversight of the outputs and resource management of the entity. Boards also hold ultimate responsibility for setting the overall strategy, determining risk appetite and overseeing the management and control of risk within that appetite, as well as ensuring there are robust decision-making processes with appropriate executive talent in place.

When a board does not exercise these responsibilities astutely, the consequences can be severe.

In Victoria’s governance model, the concept and practice of good governance is crucial – the State cannot run without its boards and boards cannot run without good governance.

But how does this governance model work in practice? And what does it mean for those members of the community who step up and take on directorships of public entities?

In order to fully understand governance in the government and health sectors, an understanding is needed of what the Victorian health service is, how it is created, and how it fits within the wider health system and government.

Health services

A health service is a statutory body established under the relevant Enabling Act.

The HSA currently categorises health services into various types: public health services, public hospitals, MPS (in essence small rural public hospitals) and early parenting centres. The HSA outlines the different provisions that apply to each.

Each health service has its own board of directors that is responsible for the effective and efficient governance of the health service. The board must ensure the health service is compliant with the requirements of the Enabling Acts. The board ensures the Minister (and where applicable, the Secretary) are advised about significant board decisions and are informed in a timely manner of any issues of public concern or risks that affect or may affect the health service.

The various categories of health services are outlined at Appendix 1.
Ambulance services

Ambulance Victoria (AV), like health services, is a stand-alone entity with its own board created pursuant to the ASA.

Emergency ambulance services are provided solely by AV. Non-emergency patient transport services are provided by AV and licensed private non-emergency patient transport providers.

AV is part of the health system and is also supported by a range of emergency service organisations including the Emergency Services Telecommunications Authority, the Country Fire Authority, the Metropolitan Fire Brigade and the State Emergency Service.

Health Purchasing Victoria

Health Purchasing Victoria (HPV) was established in 2001 as an independent statutory authority under the HSA, responsible to the Minister for Health.

HPV was established to improve the collective purchasing power of Victorian public health services and hospitals and achieve best value outcomes in the procurement of health-related goods, services and equipment through more than 48 contract categories.

HPV works in partnership with health services to understand their requirements, facilitate large-scale tenders and manage common-use contracts on behalf of the state. HPV also takes a lead in identifying and evaluating opportunities for collective procurement and projects that enhance public health procurement capability.

Beyond procurement, HPV works towards driving end-to-end supply chain reform across the health sector.

HPV is responsible to the Minister for Health and works closely with DHHS. As HPV continues to grow its value under contract and expand into non-clinical and greenfield contracts, its aim to achieve best-value supply chain outcomes will remain paramount.

HPV’s role is to:

• facilitate the supply of goods and services on best-value terms
• provide advice, staff training and assistance
• develop and implement policies and practices to promote best value and probity
• monitor health service compliance with HPV purchasing policies and directions
• foster improvements in the use of systems and e-commerce
• maintain useful data and share it with health services
• ensure probity is maintained in health service purchasing, tendering and contracting.
Mental health services

The Victorian Institute of Forensic Mental Health (VIFMH), also known as ‘Forensicare’, is also a statutory authority with its own board created pursuant to the MHA. Forensicare delivers inpatient and community forensic mental health services across Victoria.

Services include: adult mental health services, aged persons mental health services, child and adolescent mental health services, Orygen Youth Health and a number of youth services state wide.

Public mental health services are provided across the State by health services. Acute inpatient services support people who cannot be assessed and treated safely and effectively in the community. Hospitals commonly provide acute inpatient services. These services provide voluntary and compulsory short-term treatment and care during an acute phase of mental illness. All specialist mental health services provide a range of community treatment and care components, located across a spectrum of continuing care that involves acute inpatient services.

Like public health services, Forensicare is governed by a board of directors. Forensic mental health is a specialist area in the mental health system. Services are specifically targeted at meeting the needs of mentally disordered offenders, i.e. effectively assessing, treating and managing forensic patients and clients and people with a mental illness who have offended - or who are at risk of offending.

Governance provisions under the Enabling Acts

Governance provisions under the Enabling Acts are very similar with respect to the role of the board, key processes and interactions with DHHS and the Minister for Health, however the relevant Enabling Act should be consulted to understand where provisions might differ. The table in Appendix 2 provides a high level summary of the key provisions of each Enabling Act with respect to governance.

The HLA Bill makes multiple amendments to the Enabling Acts. These are highlighted throughout this toolkit and summarised at the end of this chapter. The table in Appendix 2 includes the amended versions of provisions and will thus remain accurate after the HLA Bill has been proclaimed.
1.2 What is governance and ‘good’ governance?

Governance is a broad concept that can mean different things to different people. Some of the core objectives of the Enabling Acts are to ensure that health services provide high quality, equitable access to health care with services that are governed and managed effectively, efficiently and economically.

In order for directors, and their health services, to apply the broad objectives of the Enabling Acts, a better understanding of what governance is and the requisite standards in a health service context is required.

Questions that directors of health services should ask

- Do I fully understand my obligations with respect to governance, including clinical governance?
- Do I, and the board, understand what governance is and what ‘good governance’ looks like?
- Does the board have a documented governance policy and agreed process?
- Do I understand the key pillars of the Victorian public health sector and the relevant governance aspects of the Enabling Acts?
- Does the board understand, and effectively fulfil, its purpose and role in decision-making, strategy setting, performance monitoring and oversight?
- Does the board ensure directors allocate sufficient time to discharge their responsibilities?

Red flags

- Directors do not have an understanding of core governance concepts.
- Directors act as community representatives rather than focusing on governance.
- Directors push personal agendas rather than the strategic goals and matters of the health service.
- Directors are unaware of their obligations, accountabilities and fiduciary duties to the entity and Minister in governing the health service.
- Directors do not understand how their performance and the performance of their health service is measured.
What is governance and ‘good’ governance?

Directors will hear the term governance a great deal.

‘Governance’ refers to the processes and mechanisms in place to support and implement decisions. It encompasses policies, procedures, systems and behaviours through which an organisation’s authority is administered, exercised and maintained. It consists of several key elements, which when combined form a governance framework.

‘Good governance’ is when these policies and processes positively support effective decision-making, transparency, strategy, accountability and performance, each of which is critical to ensuring the ongoing viability of the health service.

Governance decisions and activities largely involve risk management, strategy development and stakeholder engagement, covering a broad range of internal and external considerations. These are broad and complex responsibilities, requiring an open and curious mind-set. Boards and directors who add value and fulfil their duties and responsibilities most effectively will:

- be comfortable with uncertainty
- have a tolerance for ambiguity
- have courage and curiosity
- be comfortable with not having all the answers straight away
- understand that their skills will need to be constantly updated.

There is generally considered to be seven elements of governance that encompass both functional and behavioural aspects fundamental to an effective and efficient board governance framework. Figure 1.2.1 below provides an infographic of the elements.

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1.2 What is governance and ‘good’ governance?/ 16
‘Good’ governance is when all these elements are being implemented effectively and therefore supporting robust decision-making.

Note that good governance does not necessarily mean that the ‘right’ decision is made, but rather, that there are systems of transparency, accountability, compliance and conduct that support the organisation’s high level decision-making.

When applied to a health setting, good governance makes certain there is accountability at every level within the organisation to create a culture that supports the identification, and continuous improvement of quality and safety outcomes. Culture is discussed in more detail in Chapter 2 - Clinical governance and Chapter 11 – Organisational leadership and culture.

**Victoria’s governance model**

Victoria’s governance model requires boards to be responsible for overseeing the performance and service delivery of their respective health service, operating within various laws, policies, guidelines and priorities set out by the Enabling Acts, DHHS and other regulatory bodies e.g. Australian Health Practitioner Regulation Agency (AHPRA).

This governance approach allows boards and their health services to make decisions to meet their stakeholders and consumer’s needs, recognising that a solution in one place – with a unique combination of patients and service demand, culture or workforce – may not be the most effective solution in another environment.

This type of governance is premised on ‘responsive regulation’, that is, accountability through agreed mechanisms or through intervention when ‘self-regulation’ falls short. Self-regulation refers to the actions undertaken by the board to assure itself that its services are high quality and safe. This approach of responsive regulation of Victorian health services aligns with contemporary governance and regulatory thinking. The regulatory systems in place, combined with sound management practices, foster strong governance for the whole health system.

Delivering public health services is a complex and challenging undertaking for the board and requires various levels of government, and public and private sector involvement. Therefore it is important to note the complexity as well as determine the health service’s scope of governance.

**Governance framework**

In establishing and defining the governance roles applicable to health services, it is useful to understand what constitutes a strong governance framework. With this in mind, roles and responsibilities, policies and procedures, and accountabilities for governance become much clearer.

The governance framework is the name given to the structures and documents in place that define what the organisation does, and how it does it, including the:

- mission statement, vision and purpose of the health service – i.e. why it exists
- roles and responsibilities of the board and its sub-committees
- key accountabilities, including how authority for decision-making is delegated throughout the organisation
- strategic objectives and performance metrics to measure how well the organisation is meeting its vision and purpose
- code of conduct that outlines the ‘way we do things’ – the values, behaviours and standards that are adopted throughout the organisation
- policy documents that set out the high level principles that are adopted by the organisation such as compliance, clinical standards, risk management and environmental management
- risk thresholds that assist the organisation to make decisions based on a level of risk acceptable to the key stakeholders.
What is governance and ‘good’ governance?

Figure 1.2.2 below gives an example outline of the inputs and enablers to deliver simple, efficient minimum standards and clear accountabilities for governance across the organisation.

Scope of governance

As discussed above, the board’s role is strategic oversight, risk management, health service monitoring, and robust decision-making. The health service board’s governance scope (i.e. the boundaries of what it does) is established and pursuant to relevant legislation (and common law duties) and generally involves, but is not limited to:

- developing the organisation’s vision, purpose, core values, strategic direction and objectives
- evaluating executive management’s recommendations on important strategic and operational matters
- ensuring that the service delivers safe, quality healthcare to all consumers, minimising risk and meeting, exceeding and continuously improving the required clinical performance standards
- scrutinising key financial and non-financial risks to which the health service is exposed, and ensuring the implementation of an effective clinical performance, risk management, compliance and internal control framework
- ensuring the adequacy of internal regulatory and policy compliance systems
- adopting appropriate ethical standards, codes of conduct and appropriate behaviours, and ensuring that these are adhered to, including by directors themselves.
- communicating and reporting to DHHS, the Minister and other key stakeholders in a transparent and insightful manner
- overseeing CEO performance management and management succession plans
- board succession and establishing / reviewing the board processes for continuous improvement and effective governance.

The governance scope of health service boards is normally established in the board charter or by-laws.
Board By-Laws

The board by-laws (or board charter) is a critical document outlining and defining the health service board’s role and accountabilities.

The purpose of the by-laws is to document the board’s terms of reference (governance scope) and to articulate the board’s approach to important governance practices.

The by-laws should contain a statement clarifying the division of responsibilities between the board (strategy and oversight) and executive management (operations), as well as the relationship to DHHS and Minister. Boards should define the roles, powers and responsibilities that it specifically reserves for itself, and those which it delegates to management.

Importantly, by-laws cannot exceed the powers granted by the Enabling Acts. For example, it cannot set a maximum number of board directors that is different to that which the Enabling Act allows. This is because the by-laws’ power comes from the Enabling Acts (e.g. the HSA).

It is also important to note that the by-laws are binding on the organisation, as such, they should as much as possible mirror, and refer to, the Enabling Acts to ensure that the by-laws do not become invalid or ambiguous. This is particularly advantageous when or if the Enabling Acts are amended, as referring to the Enabling Acts will enable the by-laws to develop over time with the amendments.

Any changes to the by-laws, objects or name of the health service requires approval by the Secretary of DHHS to ensure consistency with the relevant Enabling Act

While the content of health service by-laws will vary from organisation to organisation, they will typically cover the following matters:

• overview of board roles, functions and responsibilities
• board structure and composition
• quorum requirements
• the chair’s role, and the role of any other defined office holders
• the role of the CEO and management
• the board’s policy for assessing their independence from management, i.e. that directors oversee and monitor the organisation rather than implement strategies, policies and procedures
• board delegations and retained authorities
• board procedures (including meetings, committee requirements, etc)
• standing committees
• oversight of strategy, financial and risk management.

The board should annually review its by-laws to ensure that they remain relevant to the circumstances of the health service. The by-laws should be available to directors, management, staff, auditors and stakeholders. See Appendix 4 for an example of a board charter or by-laws.

The by-laws may also contain rules around expected director conduct and performance however this may also be in a separate document such as a conduct charter. Please refer to Chapter 11: Organisational culture and leadership for a more detailed discussion.
1.3 Interacting with government

The roles, responsibilities and expectations of public health directors, while similar to their corporate counterparts, are substantially different in some respects and create a number of different accountabilities. Understanding the role of the public health board, the Minister, DHHS, the broader Victorian Government as well as the interactions between these parties, is critical to meeting those accountabilities.

Questions that directors of health services should ask

- Do I understand my responsibilities under other relevant legislation governing public entities (e.g. financial management and public administration legislation) and in relation to compliance with that legislation?
- Do I understand the board’s role in relation to DHHS, the Secretary, the Minister and Parliament?
- Are each of our board directors displaying strong working knowledge of the Victorian Government’s strategic health priorities and health funding policy?
- Am I adequately informed about the policy context and broader issues that impact the health service’s ability to meet its strategic objectives?
- Is there an effective framework for community engagement?
- Does the board have strong working relationships across the organisation with DHHS, the Secretary and Minister?

Red flags

- The chair of the board does not have regular communications/interactions with DHHS.
- The health service or the board receives a written direction from the Minister or Victorian Government in respect of a particular issue (not a written direction setting general expectations, which is becoming increasingly common).
- The CEO sits in on the interview for the appointment of any board director.
- There are no frameworks for the entity to engage with the community.
- The directors fail to act in the public interest when making decisions.
- The health service’s strategic direction does not align with Victorian Government policy.
- The board ignores DHHS’ and/or Minister’s strategic priorities in its decision-making framework.
- The board does not seek appropriate approvals from DHHS e.g. for a CEO appointment.
- The board does not follow guidance/instructions from DHHS.
- Directors display a lack of understanding of Victorian Government funding and budget processes.
- The board or its directors do not have any links or interactions with other public boards.
Roles and responsibilities

A health service board, and its individual directors, has/have formal duties and responsibilities to the Secretary, the Minister and the public. Therefore, it is important to understand how the chair, the board collectively, each individual director and the CEO roles relate to, and interact with, the roles of the Minister, DHHS and other key and ancillary stakeholders.

The DHHS is a key entity for boards, and acts in a variety of capacities, including in its stewardship role. Figure 1.3.1 below sets out the overarching structure and key stakeholders in the Victorian governance model.

The Victorian Government sets health policy and, in addition to DHHS, the central agencies of Department of Premier and Cabinet (DPC), and the Victorian Public Services Commission (VPSC) as a sub-entity of DPC, and the Department of Treasury and Finance (DTF) also have roles in broad policy development and the provision of advice to the Victorian Government.

DTF also plays a leading role in economic, financial and resource management, and formulates and implements the Government’s budgetary and financial policy objectives.
Under Victoria’s governance model, the roles and responsibilities of all relevant parties vary, but are equally important. The following figure highlights the various interactions between the numerous parties involved with health service delivery.

**Figure 1.3.2 The relevant key stakeholders, agencies and entities in the Victorian public health sector**
Role of the Minister for Health

The role of the Minister is also established in the Enabling Acts and at a high level, responsibilities typically include:

- setting the overall strategic direction and context of the health system in Victoria (see Health 2040 below for more detailed information)
- monitoring the performance of health services
- establishing and maintaining appropriate accountabilities and controls to ensure the provision of high-quality and cost effective health services in accordance with Victorian Government policy and objectives
- approving the strategic plans and annual performance priorities and targets of ‘public health services’
- appointing board directors and/or delegates/administrators (as required under conditions specified in the Enabling Acts)
- issuing directions to health service boards with respect to any matter of ‘public interest’ or that will ‘give effect to the objectives of the act’
- sanctioning non-performance of a health service, should it not be meeting performance expectations or targets.

Role of the Secretary

The Secretary (supported by DHHS) is responsible for ensuring that the objectives of the Enabling Acts are met through:

- advising the Minister of the operation of the Enabling Acts
- developing policies and plans with respect to health services provided by healthcare agencies
- funding or purchasing health services and monitoring, evaluating and reviewing publicly funded or purchased health services
- encouraging safety and improvement in the quality of health services provided by healthcare facilities
- approving CEO appointments and terms and conditions and health service by-laws
- developing performance criteria and measures that enable effective monitoring of the health service’s achievement of its strategic objectives
- monitoring performance across multiple domains, including access, timeliness, efficiency, quality and safety, occupational health and safety (OH&S). Please refer to the Performance Management Framework (PMF) and Victorian government’s clinical governance framework for more information.
- collecting and analysing data that enables the comparison of performance of health services.

In addition, the Secretary (supported by DHHS, Safer Care Victoria (SCV) and the Victorian Agency for Health Information (VAHI)) assists the Minister with broader administrative functions including:

- providing advice regarding state wide health strategy, policy and program development
- governance and performance of health services
- facilitating service and capital funding
- providing funding policy and allocation guidelines. Each year, DHHS publishes the Victorian health policy and funding guidelines, which set out the key budget, program and policy changes

for the coming financial year

- monitoring quality and safety and supporting services to manage and improve quality and safety
- monitoring and ensuring delivery of policy and performance priorities
- ensuring health service compliance with departmental policies and procedures.

Furthermore, making safety and quality improvement is a core goal of DHHS, as well as the broader health system. DHHS must set clear expectations that boards of all hospitals:

- have safety and quality as a substantial agenda item at every meeting
- have a statement of ambition for achieving excellence in care, and set clear, measurable goals and timelines for achieving that ambition
- hold CEOs to account for actions taken to improve care after safety incidents occur, including by ensuring that recommendations from reviews and root cause analyses are implemented.

**DHHS’ role and areas most relevant to health services**

DHHS was established on 1 January 2015, bringing together the functions of health, human services and sport and recreation. DHHS has responsibility for developing and delivering policies, programs and services that support and enhance the health and wellbeing of all Victorians. DHHS take a broad view of the causes of ill health, the drivers of good health, the social and economic context in which people live, and the incidence and experience of vulnerability. This allows DHHS to place people at the centre of policymaking, service design and delivery.

The DHHS’ structure provides for integrated stewardship of the systems and outcomes in health and human services.

Central divisions lead policy development, service and funding design and system management. Four operational divisions oversee and coordinate the delivery and funding of services and initiatives across 17 areas of the state. Each division covers a mix of rural, outer-metropolitan and inner-metropolitan areas of Victoria. DHHS provides many services directly to the community through its operational divisions. In addition, DHHS funds almost 2,000 other organisations to deliver vital health and human services care. DHHS also partners with other parts of the Victorian public service, federal and local governments and communities to build community infrastructure capacity, participation and resilience.

DHHS’ strategic plan and annual report describe its structure and divisions. Of particular relevance to health services are the following divisions.

**Health and Wellbeing division**

The Health and Wellbeing division is responsible for policy, strategy and commissioning of services in Victoria’s primary prevention, secondary and tertiary healthcare system. Health and Wellbeing oversees policy, system design and planning, as well as funding and performance of the secondary and tertiary health system (and parts of the primary care system) in Victoria.

This includes community health services, public and private hospitals and day procedure centres, emergency and non-emergency patient transport services, residential aged care services, mental health services, public dental services, drug harm reduction, treatment and support services, community care and assessment for people aged under 65 and other non-government healthcare providers. It aims to improve equity of access to services regardless of where the patient lives. The division also has a focus on integrated care for chronic disease patients, recognising the benefits of care coordination and supported navigation to improve health outcomes.

Within this division are branches and units that work together to commission services, develop health policy, monitor and oversee performance and ensure delivery of government policy. Areas most relevant to public health entities include:

- health services governance (board appointments, training, capability)
• metropolitan health service performance (monitors and oversees performance management of metropolitan public health services, development of performance management framework)
• rural and regional health (rural and regional policy, liaise directly with the board chairs and CEOs of rural and regional services, monitors and oversees performance)
• ambulance services (oversees ambulance policy and performance of emergency and non-emergency ambulance services)
• mental health (oversees mental health policy, monitors and oversee performance of mental health service providers).

Other areas in the division that the health service is likely to be impacted by, but not necessarily make direct contact with, include:
• policy and programs (tertiary and primary health policy and program initiatives, in addition to other services including aged care)
• Aboriginal health and wellbeing
• Office of Prevention and Women’s Equality
• Family Violence and Protection Agency
• Prevention Population Health and Place

The division also works closely with the Inter-governmental Relations areas of DHHS and central agencies (DPC and DTF) to advance the State’s interests in the range of agreements with the Commonwealth, such as the National Health Reform Agreement and the various National Partnership Agreements.

Working closely with SCV, Family Safety Victoria and VAHI, the Health and Wellbeing division advances safe, quality healthcare and disseminates innovation and improvement efforts across the health system. It also works alongside these organisations to maximise the value and appropriateness of care in our health system.

Regulation, Health Protection and Emergency Management Division

The Regulation, Health Protection and Emergency Management division brings together professional and epidemiological expertise to protect the Victorian public from avoidable harm. The daily work of the division brings its staff in contact with drugs and poisons, infections and contagions, emergency incidents and the risks of super bugs and pandemics.

Corporate services

The Corporate Services division provides strategic advice and services to drive performance and improve the financial sustainability of the department and portfolio agencies. The division delivers finance, business technology and information management services. It also provides expert support on industrial relations, procurement and contract management, risk identification and management, budget strategy and corporate planning.

Role of the board

The role of a health service board is to oversee the performance of its health service and ensure that it is meeting the policy and performance objectives of the Minister.

In practice this includes, among other things:
• setting the vision, strategy and direction of the organisation, in line with Victorian Government policy
• having ultimate accountability for the delivery of safe and quality care
removal, succession planning and performance management of the CEO
overall oversight of the performance and delivery of key policy priorities
ensuring the ongoing financial viability of the organisation.

The functions of the board are varied and cover accountability to stakeholders and leadership both internally and externally, now and into the longer term. Figure 1.3.3 depicts this.

![Figure 1.3.3 Health service board functions (Source: Victorian Government)](image)

The general responsibilities of boards, whether they are corporate or government entities, are similar and encompass the roles and responsibilities outlined throughout.

However, boards of government entities are additionally responsible for ensuring that they support their respective Minister in achieving their policy priorities as well as the objectives of the relevant Enabling Act.

The responsibilities of health service boards typically include, but are not limited to:

- provision of safe, high quality health care across a range of essential health care services
- efficient, effective and economic governance and management of the health service
- effective and appropriate use of public funds, allocated according to need
- providing the community with sufficient information to make informed decisions about their health care
- provision of an inclusive and safe work environment for health service workers.

The key principle underpinning this responsibility is that the board is accountable to the Minister for the performance of the health service.

The Enabling Acts define specific functions for boards including:

- developing the annual Statement of Priorities (SoP)\(^3\) and Strategic Plans for the operation of the health service and monitoring of compliance with those statements and plans
- developing the financial and business plan, strategies and budgets to ensure accountable and efficient provision of health services and the long-term financial viability of the health service

\(^3\) or equivalent health service agreement with DHHS or Minister (e.g. tripartite agreement).
• establishing and maintaining effective systems to ensure the services provided meet the needs of the communities serviced by the health service and that the views of consumers and providers of the health services are taken into account

• monitoring the performance of the health service to ensure that the health service is financially viable, effectively manages risk, develops strategic direction (in line with broader policy objectives), provides a high quality of care and drives continuous improvement across the health sector

• appointing the CEO (subject to Secretary approval) and making recommendations with respect to their remuneration and contractual agreements

• establishing the management structure and appropriate committee structures that support the implementation of the health service strategic plan in line with budget

• monitoring the performance of management (including the CEO) in accordance with strategic and performance targets

• ensuring that the CEO convenes an annual meeting of the health service between 1 July and 31 December in which the board is required to submit an annual report that incorporates operating and financial performance (in accordance with the Financial Management Act 1994 (FMA), and the health services provided and planned in the coming year.

Boards and individual directors must ensure that they:

• are familiar with the requirements of the Victorian Government’s clinical governance framework, and meeting the performance expectations that it sets out

• are aware of the policy and funding changes that impact their health service and the broader delivery of health services in and around their region

• understand the ‘whole of system’ stewardship role DHHS plays within individual programs and state wide policy setting and how health services integrate across the broader health services landscape

• develop and maintain effective working relationships between DHHS, the chair and the CEO so that each party can fulfil their responsibilities.

Directors, particularly of public hospitals and MPS, should note the expanded expectations of boards consistent with those obligations already required of public health service boards, as a result of the Health Legislation Amendment (Quality and Safety) Bill 2017 (HLA Bill) to be proclaimed in the first half of 2018.

To view the Bill and its explanatory memo, please visit www.legislation.vic.gov.au. A summary of the changes the HLA Bill will make to the Enabling Acts is at the end of this chapter.

Key attributes of directors

• Curiosity
• Healthy scepticism
• Collaborative
• Professional
• Self-reflective
• Open to challenge and discussion
• Ability to ask questions
• Can maintain a united front
• Respects confidentiality
• Integrity
• Independence from conflicts of interest

Source: KPMG
Role of the chair

The chair plays a crucial leadership role in facilitating the effective contribution of all directors and promoting constructive and respectful relations between all directors and executive management. As the leader of the board, the chair also has a performance management role with respect to other directors.

The chair must lead by example, displaying the utmost professionalism and engaging in conduct that is beyond reproach. In this sense, it is difficult to imagine a well-performing board without an effective chair.

An effective chair must:

- actively engage in inclusive leadership that ensures all directors can, and do, contribute to board discussions in a collegiate and constructive manner
- ensure that the board fulfils its role to proactively oversee and govern the organisation rather than being a ‘rubber stamp’ for management
- demonstrate personal integrity through ethical behaviour and exercise power in the appropriate manner
- provide leadership by empowering and motivating board colleagues
- develop a positive relationship with the CEO and senior management
- command respect by winning the confidence of fellow directors
- demonstrate strong communication skills, both verbal and written
- understand and demonstrate a commitment to corporate governance principles and practices
- operate as a team player, respecting, acknowledging and building on the views and perspectives of others
- promote a suitable vision and strategy, offering strategic insight and direction
- manage board meetings and procedures including time management and development of agendas
- performance assessment and management
- leads succession planning for board and key executives
- oversee the development of a sound risk management framework.

The duties of the role and the personal characteristics and competencies required should be embodied in a chair’s position description that is reviewed by the board on a regular basis. The expectation of the role are the same as for other public sector entities as outlined in the VPSC guidance.

The VPSC guidance acknowledges the demanding and time-consuming nature of the chair’s role and specifically describes the role’s importance in leadership and relationship management, particularly with the CEO, DHHS and the Minister.

The importance of the chair’s role with respect to leading the board, maintaining relationships and overseeing effective performance of the health service means that other commitments must not be allowed to detract from the chair’s role.

The chair may be exposed to ‘additional liability’ if circumstances arise where they could be considered

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a recipient and ‘gatekeeper’ of information that may not be available to other directors. It is paramount to ensure that any significant performance shortcomings attributed to the CEO are brought to the board’s attention and that the chair resists any complicity with the CEO to hold back information.

In addition, the chair must not prevent the CEO from raising issues with the board, nor should the chair fail to raise any matter that would reasonably be judged worthy of the board’s consideration.

Given the significance of the chair’s role, boards should give careful attention to the election of a chair. The common practice of electing a chair according to a notion of seniority should not be the default position. The role should be filled by the candidate best able to fulfil the duties referred to above.

**Role of the director**

Board directors are bound by legal and ethical responsibilities enshrined in the Enabling Act and supporting governance guidelines. Appointed by the Governor in Council (GiC) on recommendation of the Minister, the role of a director is to fulfil their directorship responsibilities, and those responsibilities outlined in the HSA, in a professional and ethical manner.

In practice, this means that directors must:

- act in the **interests of the health service** at all times
- act with **integrity and in good faith**
- hold themselves and each other **to account**
- attend **all meetings**, having pre-read all board papers
- look **beyond the obvious** and not just accept the information presented
- be **curious and well informed** – inform themselves of issues/risks impacting the provision of health services.

**Indemnity**

Various sections of the Enabling Acts stipulate health service board directors are not personally liable for anything done, or omitted to be done, in good faith when carrying out their duties. Any liability resulting from an act or omission attaches instead to the health service.

Victorian Government health service insurance covers the corporate liability of public health services arising from negligent medical treatment, as well as the individual liability of those for whom the hospital is legally liable such as full-time and part-time employed doctors (including private practice work that is specifically covered by the insurance), and contracted visiting medical officers undertaking public work. Sum insured limits apply, which are reviewed for adequacy by the VMIA as part of their role as risk advisor to the government.

The precise nature and extent of an indemnity in any particular case will depend on the circumstances involved. Board members should seek independent legal advice concerning whether they need to take out additional insurance to cover all circumstances.

**Role of the Chief Executive Officer (CEO)**

The appointment (or re-appointment) and performance management of the CEO is a critical role for the board of directors. The Chair in particular, has a critical relationship with the CEO as the conduit between the health service and the board.

Board Directors, particularly of public hospitals and MPS, should note their additional performance management obligations for CEOs as a result of the HLA Bill (to be proclaimed in the first half of 2018). The HLA Bill requires that the board monitor the performance of the CEO of the public health service (including at least one formal assessment in relation to that financial year), having regard to the objectives, priorities and key performance outcomes specified in the service’s statement of priorities (or equivalent agreement).
Health service CEOs have a broad range of responsibilities and are required to take direction from the board with respect to:

- managing the health service in accordance with the financial and business plans, strategies and budgets developed by the board
- preparing material for consideration by the board, including SoPs, strategic plans, business plans, strategies and budgets
- ensuring the board and its committees are assisted and provided with relevant information to enable them to perform the functions effectively and efficiently
- implementing effective and accountable systems to monitor the quality and effectiveness of health services provided
- ensuring the health service continuously strives to improve the quality of health care it provides and to foster innovation
- ensuring the board’s decisions are implemented effectively and efficiently throughout the health service
- informing the board, the Secretary and the Minister without delay of any significant issues of public concern or significant risks affecting the health service.

The HSA also articulates that in performing his/her duties, the CEO must do so with the needs of the key stakeholders and users of the health service in mind and ensure these needs are met in a cost effective and efficient manner.

The CEO must also ensure resources of the Victorian public hospital sector generally are used effectively and efficiently taking into account the broader health system.

**Delegated authorities**

Given the complexity of a health service, it is not possible, nor is it desirable, for a board to exercise all of its possible powers and functions all the time. The board may sometimes delegate part of its powers to a sub-committee, an individual director, and/or an employee under a defined ‘Delegations of Authority’ document, endorsed by the board.

Directors are entitled to rely on others, where they believe, on reasonable grounds, in good faith and after making all proper enquiries that the delegated authority is, and will continue to be, reliable and competent in relation to the power delegated.

Importantly, a delegation of authority is not a delegation of a director’s accountabilities. A director will always be responsible for performing the duties of his/her role in accordance with the Enabling Acts and his/her inherent responsibility to act in the best interests of the organisation under the direction of the Minister.

If these conditions stop being met, the board will be responsible for the exercise of power by the delegate as if the directors themselves had exercised the power. The board also retains the delegated power and can still exercise it.

Boards must take responsibility not only for the appointment and performance management of a reliable and competent CEO, but must also make a judgement about the competence of the entire senior management team, as well as being satisfied that the organisation has established proper processes for the management of the organisation, and the hiring of competent employees.

It is important that directors review all materials and financial reports presented by management and auditors with a critical eye, and not accept or approve materials without question, to ensure that reasonable grounds exist to rely on the work of management. Directors should seek source documents.
and other information and materials to understand the presented information in context.

The delegations policy, which is approved by the board, should specify the limits of authority for all individuals, including the delegations from the CEO to senior management and from senior management to staff. This will assist the board in fulfilling its duty of care and be a useful reference to all health service personnel as to who has responsibility for decision-making.

Government is different

As iterated above, governance of a Victorian Government entity is different from the private and not-for-profit sectors. Figure 1.3.4 below highlights five key factors that sets Victorian Government agencies apart.

![Figure 1.3.4- Unique factors of governance for Government entities (Source: KPMG)](Image)


Other legislation and policies

In addition to a health service’s enabling legislation, there is a wide range of other legislation applicable, both state and federal. A director should be fully aware of relevant laws including:

- overarching Victorian Government legislation and policy
- other legislation, Victorian Government policy and obligations relevant to the health service’s activities
- guidelines and directions issued by the Minister, Victorian Government departments or other regulators.

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Common examples of overarching government legislation (at both state and federal levels) includes disclosure, privacy, financial management, general public administration, equal opportunity, freedom of information and public records. Policies can include those related to industrial relations, public sector employment principles, procurement, advertising, risk management, litigation, and investments.

The health service should advise the board, and the board should also be broadly aware, on which overarching government policy frameworks and any specific departmental polices, apply to their health service. Directors should thoroughly review the key organisational specific policies and assure themselves that they are fully aligned with government requirements before endorsing them. Formal Ministerial directions can override some policies, if the government’s overarching policy or the health service’s legislation permits this.

Whilst health services are exempt from the Corporations Act 2001 (Cth) (which outlines the roles, responsibilities and accountabilities of directors and organisations outside the public sector), they are subject to all the other laws that apply to the private sector, including occupational health and safety and taxation. Government agencies are normally expected by the community and other regulators to be exemplars in compliance with these requirements.

**Upcoming legislative changes**

The Health Legislation Amendment (Quality and Safety) Bill 2017 received Royal Assent on 24 October 2017 and will be proclaimed in part during the first half of 2018 (with the remainder coming into effect on the default date). The HLA Bill represents foundational work to improve the governance, oversight and regulation of agencies providing health services to the Victorian community. The bill amends a number of health portfolio acts to prioritise the importance of quality and safety and establish strong and consistent statutory responsibilities for quality and safety. It does this in relation to public health and ambulance services through improved governance arrangements and an expanded suite of powers available for departmental oversight and appropriate interventions.

The reforms in this bill will support objectives that were identified in Targeting Zero, namely:

- committing to stronger leadership of quality and safety of the health system;
- engaging clinicians in system improvement and oversight;
- elevating quality and safety in health service governance;
- making better use of information to improve quality and identify and act on risk;
- strengthening departmental oversight and regulation for safer care and quality improvement.

The HLA Bill addresses those recommendations identified as requiring early, urgent implementation through legislation, and represents the first stage of statutory reform to deliver improved safety in health services and better care for patients. Some Targeting Zero recommendations that suggest legislative change have not been included in this bill. Those that require further consultation or complex analysis of the legislative framework will be included in the second stage of statutory reform. This second stage will build on the changes arising from this first bill with a particular focus on further enhancing the flow of information in the health system.

A summary of the changes for health services and the corresponding amendments to the Enabling Acts is provided at the end of this chapter.

The Health and Child Wellbeing Legislation Amendment Bill 2017 was introduced into Parliament in November 2017 and will improve the operation of three important regulatory schemes introduced by the Andrews Labor government — no jab, no play, the reportable conduct scheme and the statutory scheme for responding to complaints made about health service providers. It will also provide for mandatory reporting of cases of anaphylaxis to the Department of Health and Human Services by hospitals.

Bills and their respective explanatory memos and second reading speeches (which detail the purpose of the Bill and what it seeks to change) are available at [www.legislation.vic.gov.au](http://www.legislation.vic.gov.au)
Elections and caretaker conventions

Standing for election

If you plan on standing for election to parliament, there are important laws and regulations that will apply.

A board director who is considering standing for Parliament or a local council should familiarise themselves with the relevant laws and their potential effect. Directors should review:

- Australian Constitution (for federal elections)
- Victorian Constitution (for state elections)
- relevant by-laws or rules of the local government (for local government elections)
- Public Administration Act 2004 (PAA)
- relevant codes of conduct (e.g. the VPSC’s Director’s Code of Conduct)
- Australian Electoral Commission guidance
- the HSA or other relevant Enabling Act (e.g. for resignation processes).

For example, under sections 49, 61, and 61A of the Victorian Constitution, a person who holds “any office or place of profit under the Crown (whether in right of Victoria or any other capacity), or is in any manner employed in the public service of Victoria or of the Commonwealth for salary wages fees or emolument” may stand for election to the Victorian Parliament provided they resign from that position if elected to Parliament. Otherwise, the person’s election may be ‘null and void’.

However, there are many cases where express provision (in statute e.g. HSA) is made to the contrary where a person can hold both positions (health service directorship and Parliament membership).

Therefore, if you intend to nominate for election to either local government, state or federal Parliament, it is recommended you seek independent legal advice. Additionally, should you be required to resign, you should also seek legal advice as to how to affect your resignation, pursuant to all relevant legal requirements, and in sufficient time for the resignation to take effect by the required date (so as to not impact your standing for election).

In addition to any rules or laws regarding the eligibility to nominate or stand for election, directors must consider whether their nomination could be in conflict with their directorship. The board must be satisfied that the director is able to continue to perform their duties without a conflict or interest or misuse of position on the board. This includes the nominated director being free from partisan or political views while on the board and not using the position as director on the board to gain some benefit toward their electoral candidacy.

For further information please visit the Victorian Electoral Commission website: www.vec.vic.gov.au and the VPSC website: www.vpsc.vic.gov.au. DHHS also offers support to its health services and board directors through its divisions and the central Health Services Governance team that developed this Toolkit.

Caretaker conventions

Caretaker conventions dictate that once an election date is determined, the government assumes a ‘caretaker role’ up until the date of the election. Prior to the election period, board directors should familiarise themselves with the caretaker conventions applicable to Victorian health services. Caretaker conventions are published on the DPC website\(^8\), once an election is announced.

\(^8\) See www.dpc.vic.gov.au
Specific published conventions are employed during this period which aim to protect the apolitical character of the public service, and limit the commitments, made in advance, of a (potential) incoming government including:

- not making any major decisions, such as entering into major contracts or undertakings, that are likely to inappropriately commit an incoming government
- running advertising or information campaigns that highlight the role of the Minister or address an issue of contention between political parties
- engaging in any other activity, such as public presentations, speeches or comment that compromises the health service’s actual or perceived apolitical status.

The board should be aware that some government or departmental decisions that might affect the organisation (such as appointments or reappointments of board directors) are not normally made during the caretaker period, and can be delayed following an election, particularly if a new Minister is appointed. The board should factor such potential delays into its planning.

More information is available from [www.vpsc.vic.gov.au](http://www.vpsc.vic.gov.au)

**External regulatory framework**

A range of external bodies have an oversight role in relation to some important components of health service operations. Boards should understand their health service’s obligations in relation to these bodies.

There is a much broader regulatory framework within which a health service operates. Key elements of this external framework include agencies established to monitor, manage and resolve issues relating to:

- consumer protection and investigation of complaints regarding health service provision, and management of health records - under the remit of the Health Complaints Commissioner (HCC)
- rights, complaints resolution and improvements for Victorian public mental health services – under the remit of the Mental Health Complaints Commissioner (MHCC)
- investigation of administrative practices of health services (conducted by the Victorian Ombudsman)
- audit and accountability of public administration of all public sector organisations, including the department and public health service entities (such as VAGO)
- unexplained natural deaths and deaths suspected to be from direct or indirect trauma which can sometimes involve investigating deaths that occur in health services (conducted by State Coroner)
- complaints about the care and services from an Australian Government-subsidised aged care service provider and reporting notifiable diseases e.g. flu (conducted by the Aged Care Complaints Commissioner (ACCC))
- the investigation of public sector practices which relate to fraud, corruption and misconduct (such as those undertaken by the IBAC)
- implementation of the National Registration and Accreditation Scheme across Australia (under the remit of AHPRA). Please note there is a distinction between accreditation (of the health service) and credentialing (of clinicians).

The role of each of these agencies is outlined in more detail in Appendix 3. More information is provided in relation to obligations to many of these regulators in Chapter 4: Statutory duties.
1.4 Government Policy

In addition to the HSA and regulatory frameworks, there are also multiple government and DHHS commitments and policies that directors need to consider. We have provided a few policy examples in this section to highlight what is currently front and centre for the health sector and DHHS.

Questions that directors of health services should ask

- Am I aware of the long term health policy drivers of the Victorian public health sector?
- Do I keep up to date with new policies, technology and other innovations that are impacting the health care sector?
- Do the board invite regular speakers to talk about recent health developments?
- Do we invite DHHS executives to board meeting?
- Are we aware of the leading policy drivers of other health services? How do these drivers affect our health service?
- Do I understand interactions of different parts of the health system?

Red flags

- The board operates in isolation from the health service and from other health services within the sector.
- DHHS has never been invited to speak at or outside of a board meeting.
- The board is unaware of recent policy publications and trends in the health care sector.
- The board is unaware of current technology and other innovations in health.
- There is little or no consideration of current or emerging health policy issues and the impact they might have on the provision of health services both locally and more broadly.
- The health service strategy lacks policy inputs and assessments of changing context of health service provision in the local community.
- Directors rarely attend training and/or sector events/conferences.
Policy introduction

Victoria’s population and labour market is growing, meaning there is more demand for the services we fund and provide. Coupled with this are significant changes to settlement of the population, with the emergence of new growth areas in Melbourne, and in the population’s demographics, such as in profiles of age, ethnicity, health and wellbeing. This is causing Victoria to re-think the optimal distribution and configuration of services and to recognise the service mix people need now will be different from future needs.

Victorians also have changing expectations and preferences about the services the Victorian Government funds and delivers. Informed by Targeting Zero, the review of hospital safety and quality assurance in Victoria and quality and safety reviews in human services, Victorians rightly expect safer, higher quality services. Victorians expect learning from the recent tragic events in the health and human services systems to deliver the Government’s commitment to zero avoidable harm.

Victorians also have a growing preference for more personalised services, more choice and greater co-design and shared decision-making. Digital media and technology are also changing how people expect to interact and engage with Government. Data, analytics and technology are transforming the ability to predict, assess and respond to risks and needs.

Some of the more recent policy items impacting health services published have been summarised below.

Health 2040: advancing health access and care

Health 2040: advancing health, access and care\(^9\) presents a clear vision for the health and wellbeing of Victorians and for the Victorian healthcare system. Health 2040 is built around three pillars:

- **Better health**: focuses on prevention, early intervention, community engagement and people's self-management to maximise the health and wellbeing of all Victorians.
- **Better access**: focuses on reducing waiting times and delivering equal access to care via state wide service planning, targeted investment, and unlocking innovation.
- **Better care**: focuses on people's experience of care, improving quality and safety, ensuring accountability for achieving the best health outcomes, and supporting the workforce to deliver the best care.

Victoria’s health policy drivers

The health care system exists to improve the health and wellbeing of all Victorians. The Victorian Government is responsible for delivering the system that looks after Victorians. It sets the direction and funds the services that people use every day.

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The Government funds more than 500 organisations to provide healthcare to Victorians. This includes hospitals and emergency services, and services provided in the community and in people’s homes. Many of these services require specialised buildings and equipment; Victoria’s public health infrastructure is worth over $11 billion.

Our public health workforce is one of the largest in Australia. The 100,000 people who work in our public health services are the heart of Victorian healthcare.

Our challenges

The health system is always evolving to meet the changing needs of Victorians. However, the changes of yesterday do not meet the demands of tomorrow. While much has been achieved over the past 10 to 20 years, far-reaching change must happen to meet the challenges we now face:

- an ageing population, together with new discoveries, new technology and new treatments which are creating growing demand for healthcare
- lifestyle choices and behaviours that are contributing to higher levels of chronic disease
- disparities and inequalities in health outcomes for certain population groups
- people’s changing needs and expectations
- unprecedented financial constraints that are unlikely to diminish.

These challenges have become truisms of the system, and it will take concerted and unified effort to address them. We must act now to effectively position our health system for the future and ensure that it is sustainable for the long term. This requires a clear vision, knowing what needs to be done to achieve that vision and deliberately charting our progress toward it.

Why we need change

Our health system performs very well overall. Nationally, Australia has one of the highest life expectancies of any country in the world and our survival rates for cancer and cardiovascular disease are among the best in the world. Compared to similar countries, Australia has an efficient health system. While much has been achieved by the efforts to improve the system, we have a long way to go in providing healthcare that centres on people, ensures their care is well-coordinated, integrates services around them and personalises the care they receive.

Priorities for reform

There are six broad themes which act as starting points for further exploration of healthcare reform direction. These are introduced below but are intended to be neither prescriptive nor exhaustive. At the heart of these themes is the idea that the healthcare system should be designed from the perspective of the people who use the system.

The six themes are:

- a person-centred view of healthcare
- preventing and treating chronic disease
- improving people’s health outcomes and experience
- improving the way the system works together
- better health for people in rural and regional areas
- valuing and supporting our workforce.

These are just some of examples of policies impacting directors when they are making decisions in the boardroom. Board chairs should keep in regular contact with DHHS to ensure they are up to date with the latest policies and commitments.
Statewide Design, Service and Infrastructure Plan

The Statewide Design, Service and Infrastructure Plan for Victoria’s Health System 2017-2037\(^{10}\) provides the planning framework that will guide service, workforce and infrastructure investment in our health system over the next 20 years, including an initial five year implementation plan.

The development of the plan during 2017-18 was guided by a Ministerial Advisory Council with broad representation from the health sector, as well as wider sector and community consultations on specific loyalty and service-stream planning issues.

The Statewide Plan describes our outlook on the future system including system design principles:

- Health system design is driven by population need, underpinned by strong prevention and early intervention systems to improve health outcomes.
- Victoria’s health services have clear role delineation, are geographically coordinated, & are well connected to the broader health & social care system.
- Where safe and appropriate, services will be delivered outside of the hospital setting and as close to home as possible.
- Enhanced system configuration and more flexible use of resources will release existing capacity in our health services and better distribute new capacity.
- Designated tertiary referral/specialist health services have a key role in ensuring access to patients from across Victoria who require higher complexity care.
- The causal relationship between the volume of services being provided and the quality of these services will be reflected in system design and service planning.
- The prioritisation and distribution of high cost medical equipment across the system will be undertaken by the department.

As discussed above, Health 2040 identified a range of challenges for the Victorian health system. The Victorian Government is responding to these pressures by delivering lasting changes to the health system, focusing on five priority areas that will chart our path forward over the coming 20 years:

- building a proactive system that promotes health and anticipates demand
- creating a safety and quality-led system
- integrating care across the health and social service system
- strengthening regional and rural health services
- investing in the future—the next generation of healthcare.

The Statewide Plan will be operationalised through planning for specific localities and major service streams, as well as the progressive development of a system role delineation framework including capability frameworks and formalised service networks.

Targeting Zero – the review of hospital safety and quality

At the request of the Minister, a review was commissioned following the discovery of a cluster of tragically avoidable perinatal deaths at Djerriwarrh Health Service.

The review, Targeting Zero, was a detailed and extensive analysis into how DHHS oversees and supports quality and safety of care across the Victorian hospital system. It consulted widely, seeking the views and experiences of patients, clinicians, hospital managers and boards about how to make Victoria's healthcare systems safer.

The Victorian Government and DHHS accepted, in principle, all the recommendations of the review, with significant work already completed to implement them.

Better, Safer Care - Delivering a world-leading healthcare system\(^\text{11}\) sets out how the Victorian Government and DHHS are addressing the entirety of the review's recommendations under four areas of emphasis:

- setting the goal that no one is harmed in our hospitals.
- supporting strong leadership in hospital governance - with good clinical leaders, effective boards and rigorous oversight.
- sharing excellence across our health system - so that where one hospital does something well, others can follow suit.
- collecting great data about patients' experiences and feeding that back across the system to improve patient care.

As part of this response, new entities have been established to simplify the current system and better respond to the needs of patients and healthcare workers:

- **Safer Care Victoria (SCV)** - an agency that works with health services to monitor and improve the quality and safety of care delivered across our health system, with the goal of achieving zero avoidable patient harm.
- **The Victorian Agency for Health**

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Information (VAHI) - a new health information agency which analyses and shares information across our system to ensure everyone has an accurate picture of where the concerns are, and where we’re getting it right.

- Victorian Clinical Councils (VCC) - putting clinicians front and centre to provide clinical expertise to the Victorian Government, DHHS and health services on how to make the system safer and provide better care to all Victorians.

- Boards Ministerial Advisory Committee (BMAC) - a committee to ensure our hospital and health service boards have the right mix of skills, knowledge and experience to strengthen governance and decision-making.


Mental Health

In November 2015 the government launched Victoria’s 10-year mental health plan[12] to guide investment and drive better mental health outcomes for Victorians. More than 1,000 Victorians were involved in development of the plan, including people with a mental illness, their families and carers, service providers, clinicians, workers, experts and community members.

Recognising that nearly half of all Victorians (45 per cent) will experience mental illness in their lifetime, the plan focuses on greater efforts in prevention, and providing better integrated services and support for the most vulnerable people in the community. The plan also outlines the government’s approach to work directly with people with a mental illness, their families and carers to co-produce and improve services. It is a long term plan that sets the mental health agenda for the next decade, not a set of one-off actions.

The plan will ensure investment in mental health is coordinated and strategic, maximising the benefits for Victorians. It is closely aligned with the MHA, which supports the provision of holistic, recovery-oriented mental health treatment - enabling people with a mental illness to play a central role in decisions regarding their treatment and care.

Additional funding in the 2017-18 State Budget means Victorian mental health services will be better

While there has been a reduction in the number of suicides in Victoria over the past year (654 in 2015), the Victorian Government is committed to halving the suicide rate in Victoria by 2025.

better and timelier access to relevant data to inform both policy and program responses. DHHS is working closely with the Coroners Prevention Unit on sharing non-identified data. This is a critical addition to existing information and knowledge including Victorian, national and international research on evidence-based responses to prevent suicide.

**Major reforms in forensic mental health**

Victoria’s 10-year mental health plan identified the critical need to better address the requirements of people involved with the justice system at all points of contact: at arrest or apprehension, in police custody, at court, on community-based corrections orders, in prison and at all transition points.

A significant proportion (36.9 per cent) of prisoners in Victoria have a psychiatric risk rating on arrival in prison. A key part of the reform is ensuring effective treatment and support is provided to prisoners on their return to the community. Investments in the 2017–18 State Budget have expanded mental health support for people who are in, or at risk of entering, the criminal justice system. The reforms aim to improve mental health outcomes, reduce the risk of offending or reoffending and increase community safety.

Six new community forensic mental health programs will be introduced in community health services to provide assessment and treatment for offenders on a community corrections order with an associated mental health treatment and rehabilitation condition.

A new Mental Health Advice and Response Service is being established to facilitate pre-sentence referrals to mental health treatment and provide clinical advice to magistrates, including preparation of pre-sentence assessment reports and court liaison. In late 2017 a triage service response to clinical mental health information requests from Victoria Police will be introduced for high-risk individuals coming before a magistrate during after-hours bail hearings.

Reforms in youth justice will provide more mental health assessment, treatment and support through clinical in-reach for young offenders in the justice system. A new Forensic Youth Mental Health Service will include an early intervention problem behaviour program, and a secure youth forensic mental health unit will be established.

An additional 18 beds will open at Thomas Embling Hospital during 2017-18. In late 2017 Ravenhall, the new medium-security men’s prison, will open in Melbourne’s west. Ravenhall will have capacity to provide mental health services to 75 inmates. Across Victoria, funding has been provided to support planning for more forensic mental health beds.

**Forensicare**

Forensicare is the state wide provider of forensic mental health services. Forensic mental health services is a specialist area of the mental health system that provides a wide range of mental health services across the spectrum of criminal justice including assessment and treatment of mentally ill offenders, people with a mental disorder and a history of criminal offending or those who are at risk of offending. It also provides treatment services for people found not guilty of an offence on the grounds of mental impairment.

The primary focus of Forensicare is the provision of clinical services which are provided in inpatient, community and prison settings. Forensicare partners with mental health services and broader community organisations to ensure patients and consumers are well supported in their recovery trajectory. Forensicare have a formal link with Swinburne University of Technology through their research arm, the Centre for Forensic Behavioural Science and established links with other tertiary organisations to support ongoing commitment to promote knowledge and training in forensic mental health.
Ambulance Services

**Victoria’s Ambulance Action Plan**

The Victorian Government established the Ambulance Performance and Policy Consultative Committee in January 2015 to develop policies and make recommendations to improve the performance and culture of Ambulance Victoria. The Ambulance Performance and Policy Consultative Committee released its final report *Victoria’s Ambulance Action Plan – Improving Services, Saving Lives* (Action Plan) on 10 December 2015. The Action Plan sets out a roadmap to transform both the delivery of ambulance services to the Victorian community and the way paramedics are supported throughout their careers.\(^{14}\)

The Action Plan is part of a broader policy reform agenda which will support efforts to shape a health system that meets the needs of all Victorians. The reform priorities in the Action Plan have been developed alongside other important policy initiatives, which focus on quality and safety, performance, workforce and culture. These include the VAGO audits on Occupational Violence Against Healthcare Workers and Bullying and Harassment in the Health Sector; the Royal Commission into Family Violence report and the SoP agreed between the AV board and the Minister for Ambulance Services.

**Ambulance Victoria**

Ambulance Victoria aims to improve the health of the community by providing high quality pre-hospital care and medical transport. AV provides emergency medical response to more than six million people in an area of more than 227,000 square kilometres.

AV’s Charter requires the service to:

- respond rapidly to requests for help in a medical emergency
- provide specialised medical skills to maintain life and reduce injuries in emergency situations and while transporting patients
- provide specialised transport facilities to move people requiring emergency medical treatment
- provide services for which specialised medical or transport skills are necessary
- foster public education in first aid.

AV was created on 1 July 2008 following the merger of the Metropolitan Ambulance Service, Rural Ambulance Victoria and the Alexandra and District Ambulance Service.\(^{15}\)

AV has undergone significant reform over the past two years, driven by the Action Plan. This has


\(^{15}\) Available from: [www.ambulance.vic.gov.au](http://www.ambulance.vic.gov.au), which contains general information about AV and is regularly updated with the latest in statistics, developments and media releases.
renewed the focus on AV’s role as an emergency ambulance service through successful completion of a range of reforms. Further, in November 2016 the Victorian Government announced a $500 million plan to further improve ambulance response times. This investment will allow AV to deliver a comprehensive and more effective response to communities across the state, and position the organisation well for the future.

In 2017, AV released its first ever Strategic Plan, which provides a framework for the delivery of ambulance services and actions to achieve intended outcomes. The 2017-2022 Strategic Plan outlines how AV will continue to provide world-class patient care in an environment of increasing demand and high community expectations. AV is committed to saving and improving lives by providing outstanding emergency health care every time.\(^\text{16}\)

The Strategic Plan provides an understanding of DHHS’ vision, aim and objectives. It is essentially the roadmap for DHHS delivering on its priorities and commitments. Having an understanding of the strategic plan and DHHS overarching goals, better prepares directors to govern health services efficiently and effectively having a better understanding of the government context.
The Department of Health and Human Services Strategic Plan

We commit to delivering the following priority actions over the next 18 months

To read the full plan, go to: http://www.dhhs.vic.gov.au/our-strategy


1.4 Government Policy/ 46
HLA Bill changes

There are a range of changes to the enabling acts of health services as a result of the HLA Bill. This HLA Bill is to come into effect on or before (if proclaimed on an earlier date) 1 July 2018.

The HLA Bill will directly amend the:

- *Health Services Act 1988* for public hospitals, MPS, public hospitals, private health service providers (e.g. day procedure centres), Better Care Victoria
- *Ambulance Services Act 1986* for ambulance services such as AV
- Mental Health Act 2014 for VIFMH
- Public Health and Wellbeing Act 2008 regarding Consultative Councils

There are also a range of other changes that provide for the development of guidelines and other such powers regarding quality and safety. In many cases, this is merely a clarification that the guidelines can be for quality and safety, not just quality (see, for example, section 12(b) of the HSA).

The changes that impact health services (public hospitals, MPS, public health services, AV and VIFMH) are detailed throughout this toolkit but can be summarised as follows:

<table>
<thead>
<tr>
<th>Change</th>
<th>Entity type</th>
<th>Amended section</th>
</tr>
</thead>
<tbody>
<tr>
<td>All health service boards are boards of directors</td>
<td>Public Hospital</td>
<td>HSA s.33(1)</td>
</tr>
<tr>
<td></td>
<td>MPS</td>
<td>HSA s.115E(1)</td>
</tr>
<tr>
<td></td>
<td>PHS</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>VIFMH</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>AV</td>
<td>No change</td>
</tr>
<tr>
<td>Functions of the board of directors made consistent across all health services boards. These functions include:</td>
<td>Public Hospital</td>
<td>HSA s.33(2)</td>
</tr>
<tr>
<td></td>
<td>MPS</td>
<td>HSA s.115E(2)</td>
</tr>
<tr>
<td></td>
<td>PHS</td>
<td>HSA ss.65S(2)(e) and (f)</td>
</tr>
<tr>
<td></td>
<td>VIFMH</td>
<td>MHA s.332A</td>
</tr>
<tr>
<td></td>
<td>AV</td>
<td>ASA ss.18(1)(e)(v) and 18(1)(g)</td>
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</table>

For some time there has been a significant difference in the statutory functions of larger public health services and public hospitals/MPS.
<table>
<thead>
<tr>
<th>Change</th>
<th>Entity type</th>
<th>Amended section</th>
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</thead>
<tbody>
<tr>
<td>despite that their risk profiles are relatively similar (albeit different in scale). As such this has been clarified. This primarily impacts public hospitals and MPS.</td>
<td></td>
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</tr>
<tr>
<td>Matters for the board to take into account when performing its functions. This includes:</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.33(2A) HSA s.115E(2A) No change No change No change</td>
</tr>
<tr>
<td>* Views of consumers * Public resources are used efficiently and effectively * The broader health sector is considered in decision making As with the above, this amendment makes the public hospital and MPS board arrangements consistent with public health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functions and powers of the entity</td>
<td>VIFMH</td>
<td>MHA ss.330(h), 330( ha) and 331(3)(c)</td>
</tr>
<tr>
<td>Appointments considerations: Minister must consider prescribed matters and tenure of the board director when recommending and appointment.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.33(10) HSA ss.115E(4A) and (5A) HSA s.65T(3) MHA s.334(3) ASA s.17(3)</td>
</tr>
<tr>
<td>Minister may appoint a Chairperson of the board</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.35A HSA s.115GA No change No change No change</td>
</tr>
<tr>
<td>* Note that the Minister is not required to appoint a Chairperson, so if this power is not exercised then the board would elect a Chairperson per their normal procedure. However, the board cannot remove a Chairperson that has been appointed by the Minister.</td>
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<td></td>
</tr>
<tr>
<td>Terms of appointment – nine year tenure limitation to eligibility for re-appointment.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.34A(1) HSA s.115FA No change No change No change No change</td>
</tr>
<tr>
<td>The Minister may make an exception to the tenure rule if he/she is satisfied that exceptional circumstances exist that justify re-appointment of the director past the nine year limit. * Previously, only GiC could exempt the tenure limitation.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.34A(2) HSA s.115FA(2) HSA s.65U(2) No change No change ASA s.17(3)(d) and 17A</td>
</tr>
<tr>
<td>Remuneration of board directors</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>No change HSA s.115F(2)(b) No change No change No change</td>
</tr>
<tr>
<td>* Previously the provisions providing for remuneration of the boards of different health services were inconsistent making it unclear if GiC was able to authorise payment in the instrument of appointment. This amendment makes the wording of the various provisions consistent to enable remuneration of board directors of all health services (i.e. public hospitals and MPS). Note that directors currently not remunerated will still require an Order in Council as the current provisions provide for remuneration per the instrument. Note that this provision has no effect on other boards of governance that may provide health-type services e.g. community health centres.</td>
<td></td>
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</tr>
<tr>
<td>The Minister can publish guidelines relating to the role and procedure of boards and how they carry out their functions (for example, deputy chairperson requirements)</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.39 HSA s.115MA HSA s.65XAB MHA s.339A ASA s.19A</td>
</tr>
<tr>
<td>Change</td>
<td>Entity type</td>
<td>Amended section</td>
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<tr>
<td>The Minister’s power to appoint a delegate to a board now includes circumstances that would improve the establishment of a new entity (e.g. a new public hospital) or improve quality and safety</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA ss.40C(1) and 40C(3) HSA ss.115MB, 115MC and 115MD HSA ss.65ZAA(1) and (3) MHA ss.339B, 339C and 339D No change</td>
</tr>
<tr>
<td>Reasons for Powers of the Minister to be exercised (e.g. appointing an administrator or closing the service) to include whether the service: has failed to provide safe, patient-centred and appropriate health services; or has failed to foster continuous improvement in the quality and safety of the care and health services it provides.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.58(1)(ca) HSA s.115Q(ba) and (bb) As per public hospital No change ASA s.35(1)(d)</td>
</tr>
<tr>
<td>Voluntary amalgamations – enabling provision</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>No change</td>
</tr>
<tr>
<td>Previously MPS were not able to undertake voluntary amalgamations with other services. They now are to be consistent with the treatment of other public hospitals and registered funded agencies. No other entity type is impacted by this amendment.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>No change HSA ss.115SA and 115U No change No change No change</td>
</tr>
<tr>
<td>Basis for amalgamations to include governance of the quality or safety of health services provided</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA ss.64 and 64A HSA ss.115SA and 115T As per public hospital No change No change</td>
</tr>
<tr>
<td>Statement of priorities now required for public hospitals (except early parenting centres). This is a formalisation of what is currently occurring in practice.</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA ss.40G and 40H No change – no SoP No change No change No change</td>
</tr>
<tr>
<td>Directions of the secretary – matters for which the Secretary may give directions that a hospital must comply with. This includes matters like conditions on purchasing, use of the service’s facilities/equipment, manner of engagement in health care provision, etc (refer to HSA s. 42 for more examples). The additional instruction matters are:</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.42(1) HSA s.115M No change No change No change ASA ss.9(e), 10(4)(ga) and (gb)</td>
</tr>
<tr>
<td>Secretary may direct a board to develop a strategic plan</td>
<td>Public Hospital MPS PHS VIFMH AV</td>
<td>HSA s.40F HSA ss.115E(2)(d) and 115NA No change No change No change</td>
</tr>
<tr>
<td>Change</td>
<td>Entity type</td>
<td>Amended section</td>
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<tr>
<td><strong>Basis for the Secretary to commission audits</strong> of any health service now includes:</td>
<td>Public Hospital MPS</td>
<td>HSA s.63A(1)(b) and (ba)</td>
</tr>
<tr>
<td>• is providing safe, patient-centred and appropriate health services; or</td>
<td>PHS</td>
<td>As per public hospital</td>
</tr>
<tr>
<td>• is fostering continuous improvement in the quality and safety of the care and health services it provides.</td>
<td>VIFMH AV</td>
<td>No change No change</td>
</tr>
<tr>
<td><strong>Clarification of Secretary’s approval required for appointment or re-appointment of CEO</strong>, and for the terms and conditions of the CEO.</td>
<td>Public Hospital MPS</td>
<td>HSA s.25(2)</td>
</tr>
<tr>
<td><em>This change was made to reflect the slightly different wording for public hospitals vis public health services in the HSA. This amendment makes it clear for all with consistent use of language. For PHS this repeals HSA s.65XA and replaces it with the new s.65S(2)(e) as a function of the board.</em></td>
<td>PHS</td>
<td>HSA ss.115JB and 115E(h)</td>
</tr>
<tr>
<td><strong>Health service boards are required to performance manage the CEO,</strong> including at least one formal assessment per year.</td>
<td>Public Hospital MPS</td>
<td>HSA s.33(2)(f)</td>
</tr>
<tr>
<td></td>
<td>PHS</td>
<td>HSA s.115E(i)</td>
</tr>
<tr>
<td></td>
<td>VIFMH AV</td>
<td>HSA s.65S(2)(f)</td>
</tr>
<tr>
<td></td>
<td>AV</td>
<td>MHA s.332A(d)  No change No change</td>
</tr>
<tr>
<td><strong>Functions of the CEO.</strong> Functions include:</td>
<td>Public Hospital MPS</td>
<td>HSA s.40I  HSA.s.115JC  MHA s.340(3)(ca)-(ch)</td>
</tr>
<tr>
<td>• To manage the health service in accordance with finance, business and strategic plans and the instructions of the board</td>
<td>PHS</td>
<td>HSA ss.65XAB(1)(d) and (e)</td>
</tr>
<tr>
<td>• To prepare material for the board regarding their SoP, implantation progress of plans and budgets</td>
<td>VIFMH AV</td>
<td>MHA s.340(3)(ca)-(ch)</td>
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<td>• To provide administrative support to board committees</td>
<td>AV</td>
<td>ASA ss.21(3)(d) and (e)</td>
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<td>• To implement effective and accountable systems</td>
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<td>• To foster continuous improvement of quality and safety</td>
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<td>• To implement board decisions</td>
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<td>• To advise the board, Secretary, DHHS, Minister of any material risks</td>
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<td>• To have regard to consumer views, use of public resources and the wider health system.</td>
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*For some time there has been a significant difference in the statutory functions of larger public health services and public hospitals/MPS, despite that their risk profiles are relatively similar (albeit different in scale). As such this has been clarified. This primarily impacts public hospitals and MPS.*
Useful references

Policy references

- Health Services Act 1988 (Vic); Ambulance Services Act 1986 (Vic); Mental Health Act 2014 (Vic) and the HLA Bill are all available from [www.legislation.vic.gov.au](http://www.legislation.vic.gov.au)
- Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants (IFAC), International Framework: Good Governance in the Public Sector (July 2014). Available here: [http://html5.epaperflip.com/?docid=7b1af6f6-7ad3-447f-93d7-a56001027e5e#page=0](http://html5.epaperflip.com/?docid=7b1af6f6-7ad3-447f-93d7-a56001027e5e#page=0)
Departments and Government Agencies

- Department of Premier and Cabinet - www.dpc.vic.gov.au
- Department of Treasury and Finance - www.dtf.vic.gov.au/Home
- VAGO’s website: www.audit.vic.gov.au
- Ambulance Victoria’s website: www.ambulance.vic.gov.au
- Forensicare’s website: www.forensicare.vic.gov.au
- Appendix 1 – List of hospital and health services
2. Clinical governance

A health service’s core product is to provide safe, effective, person-centred care to patients across a range of service types. Clinical governance must therefore be central to the board’s role, with compliance requirements and duty of care obligations paramount to strategy, risk and performance oversight.

Questions that directors of health services should ask

- Am I fully aware of my responsibilities with respect to the provision of clinical services?
- How does the board comfort itself that clinical governance is being managed effectively throughout the organisation?
- What are the major clinical risk areas that the health service is exposed to?
- Does the board, and do I, have the appropriate clinical and governance skills to monitor the provision of safe clinical care services and identify any emerging risks?
- Is the information reported by management relevant to the health service’s key clinical risks?
- How does the board visibly support consumers, clinicians, managers and staff to achieve safe, effective care?
- Does the board have an understanding of clinical risk thresholds and tolerances, to enable identification and escalation of risk mitigation actions?
- Does the board have a clear view of how our clinical services perform against other services?
- What does this information/data mean? Is it good or bad?
- How does it compare to ‘normal’ performance?
- If there is a problem identified:
  - What is being done to remedy the problem and/or improve performance?
  - How will the board and the health service be able to monitor this?
  - What milestones or targets could monitor improvement/success?
  - When is the next report on it?
- Does the board regularly engage with clinicians to detect and understand issues?
- Does our health service have the required accreditation in place to enable it to provide the relevant clinical services?
- What checks and balances are in place to monitor the effectiveness of our clinical risk management strategies?
Red flags

- Directors are unable to articulate the top clinical risks faced by their health service.
- Clinical reports from management are approved by the board without question.
- The board rarely, or never, hears from clinical staff about clinical matters.
- Staff / workplace culture issues are not recognised as risks to clinical safety (for example, low response rates to staff surveys and/or poor rates of engagement with safety culture questions in the People Matter Survey).
- There are no board directors with clinical practice skills on the board.
- Variances and trends in clinical risk performance data is not discussed or questioned by directors.
- Performance reports are provided in an ad hoc manner and/or an inconsistent format.
- The majority of the board’s directors leave questioning of clinical performance data to the 1 or 2 clinical specialists on the board.
- No benchmarking of clinical performance is undertaken.
- Clinical risk issues emerge ‘without warning’ and the board spends too much time dealing with emergency clinical risk situations.
- No director is inducted or trained in clinical governance.
- Report acronyms and variances are not explained or annotated.

Introduction to the chapter

Safe, high quality, person-centred care is the core objective of Victorian health services. In response to clinical governance failures across not only Victoria, but other states and countries, the focus on ensuring high quality care as a health service’s number one priority has been re-emphasised through the establishment of SCV and the update of the Clinical Governance Framework.

Effective leadership, risk oversight, clinical practices and consumer and workforce engagement have been highlighted as critical to achieving the policy objectives of the Victorian Government’s ‘Targeting Zero’ policy are met.17

This chapter contains:

- details of the board’s role in clinical governance
- the Victorian Government’s Clinical Governance Framework (as developed and published in June 2017 by SCV).

---

2.1 The role of the board in clinical governance

The board has ultimate accountability for the safety and quality of care. The development of the Victorian clinical governance framework is based on several key principles:

- excellent consumer experience
- clear accountability and ownership
- partnering with consumers
- effective planning and resource allocation
- strong clinical engagement and leadership
- empowered staff and consumers
- proactive collection and distribution of critical information
- openness, transparency and accuracy
- continuous improvement of care.

Every staff member has a role in the patient’s journey however the board has ultimate accountability for ensuring the safety and quality of care provided within their health service.

Together, boards and management are responsible and accountable for ensuring the systems and processes are in place to support clinicians in providing safe, high-quality care, and in ensuring clinicians participate in governance activities. Boards are responsible for monitoring the effectiveness of systems and processes at a higher level than health service management.

The responsibility for designing and implementing systems and monitoring the effectiveness of clinical care is appropriately delegated to managers and healthcare professionals with specific expertise. Clinicians and clinical teams are responsible and accountable for the safety and quality of care they provide. Kitchen staff, cleaners, suppliers, contractors and allied health workers also play a key role in ensuring safe and effective, person-centred care. Everyone has a part to play, but the board has ultimate accountability.

What is clinical governance?

Clinical governance is the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred healthcare underpinned by continuous improvement. As health services go about providing care to consumers, the clinical practices, the culture of the organisation and the checks and balances in place to ensure this care is of the highest quality — all form part of the clinical governance framework.

SCV developed a clinical governance framework titled *Delivering high-quality healthcare – Victorian clinical governance policy framework*. This framework explains and details the importance of providing safe, quality care and the key elements of an effective clinical governance system.

Clinical performance reporting

As a key source of information, clinical performance reporting should be a regular item on a board’s meeting agenda. There is a range of clinical governance reports that health service boards should regularly monitor. The board should ensure management provide systematic reports across the range of quality and safety assurance activities. Examples of clinical reports are provided in Appendix 8. For additional guidance, contact SCV.

---


Reading and interpreting clinical reports

Boards must review and interpret clinical data on a regular basis. Whilst many board directors do not have a clinical background, directors should ask various questions to assure themselves and discharge their obligations and duties. Some questions are set out below:

- What are the variances (differences or changes) in current performance against previous performance/actuals? (i.e. how do the results compare to this time last year, last month?)
- What are the variances (differences or changes) in the actual performance against targets or budgets?
- Is the variance good/favourable or bad/unfavourable (noting that an increase in one measure can be good or bad depending on the measure)? Am I satisfied with the explanation for the variance?
- Has management provided me with enough information to understand the reason for a good/favourable outcome? Do I understand how good outcomes relate to other aspects of health service governance (e.g. DHHS funding, monitoring)?
- Has management provided me with enough information to understand the reason for a bad/unfavourable outcome?
- Am I confident that the steps being taken to address an unfavourable performance outcome, including the process/tracking in place to monitor the effectiveness of the steps, are working?
- Am I satisfied with the explanation of the context of the variance (e.g. trends over time, comparison with peers, comparison with state average, comparison with benchmarks and targets)? Do management’s explanations seem reasonable based on what I know about the health system and key clinical risks?

Further guidance on understanding data is in Chapter 14: Understanding Data of this Toolkit.

DHHS’ role in clinical governance

DHHS has overall responsibility for ensuring that health services achieve the Ministerial policy objectives for Victoria’s public health sector. Their role is to:

- establish and communicate the policy objectives of all health services, of which safe, effective clinical outcomes is a priority
- provide appropriate mechanisms to support health services meet these clinical objectives, including resources, training and tools (such as this Toolkit) to assist boards, directors and management fulfil their duties
- work with relevant agencies to provide guidance and support on key areas of priority:
  - SCV is responsible for monitoring and improvement of the quality and safety of case delivered across the Victorian health system, with the goal of achieving zero avoidable patient harm.
  - BCV is responsible for advising the Minister on health sector innovation that will support the State’s healthcare reform agenda in light of increasing pressure on health services.
  - VCC comprises senior clinicians from across the State – including representatives from SCV – responsible for establishing a forum for clinicians to provide clinical expertise the Government, DHHS and health services on how to make the system safe and provide better care for all Victorians.
2.2 Victorian Clinical Governance Framework

An updated and revamped Victorian Clinical Governance Framework was published in June 2017 titled *Delivering high-quality healthcare – Victorian Clinical Governance Framework*.

This was created by SCV and provides the most up to date guide for clinical governance in Victoria. An exact copy (with some formatting modifications to enable navigation within the broader Toolkit) of that publication is below.

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Delivering high-quality healthcare
Victorian clinical governance framework

June 2017

2.2
Victorian Clinical Governance Framework / 58
To receive this publication in an accessible format, email safercarevictoria@dhhs.vic.gov.au
Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne
©State of Victoria, Department of Health and Human Services, June 2017
Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.
ISBN/ISSN 978-0-7311-7206-1
As the inaugural chief executive officer of Safer Care Victoria, I am delighted to release this updated framework to inform and guide good clinical governance, Delivering high-quality healthcare. This update has been written to better meet the needs of health services as we, together, seek to deliver the ambitious recommendations set out in the recently released Targeting zero: the review of hospital safety and quality assurance in Victoria (Duckett) report.

The refreshed framework has been developed with input from an expert group and informed by extensive sector feedback. I believe that it clearly articulates the Victorian Government’s expectations regarding clinical governance. Our intent is that it also provides practical guidance on the systems and processes needed for delivering on our shared goal of outstanding healthcare for Victorians. Always.

All Victorians have the right to expect and receive consistently safe and high-quality healthcare. Effective clinical governance systems are fundamental to delivering on that expectation. Being effective means that clinical governance must be tailored and scaled to suit health services’ circumstances and be regularly reviewed, evaluated and amended. Only in this way can we hope to drive continuous improvement to better patient outcomes and zero avoidable harm.

Our purpose at Safer Care Victoria is to help enable all health services to deliver safe, high-quality care and experiences for their patients. I hope this framework assists that purpose.

Of course, the framework is not an end in itself. I am pleased to let you know that significant other work is well underway to improve and enhance the way in which the government supports health services in providing safe, quality care. Safer Care Victoria will have a particular focus on strengthening patient experiences and partnerships and on enhancing and measuring clinician engagement. Healthcare begins with a patient–clinician encounter. Quality and safety also begins there.

I and our teams at Safer Care Victoria look forward to working closely with health service staff, the Department of Health and Human Services, the Victorian Agency for Health Information and consumers as we strive to achieve zero avoidable harm.

Victoria has a healthcare system that we can all take great pride in. I appreciate the effort and contribution that you make every day to ensuring Victorian health services are providing safe, quality care. I hope you find this framework helpful in your work.

Professor Euan Wallace AM
Chief Executive Officer Safer Care Victoria
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Part 1: Overview – context, principles, expectations and roles

Clinical governance: the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred healthcare underpinned by continuous improvement.

Context
Healthcare is inherently complex and high risk. High-quality healthcare requires continued commitment from all staff to the pursuit and maintenance of excellence. Whether that excellence is in an operating theatre or in a clinic or on a ward, whether it is clinical or in cleanliness, or timeliness or in food preparation, each and every component of healthcare counts. Just ask the patients. Fundamental to such excellence and to providing quality person-centred care are robust, integrated clinical governance systems. Safer Care Victoria requires all health services to have formal clinical governance structures and functions in place. We also require that those structures and functions are evaluated regularly for their effectiveness in driving continuous improvement. Boards hold this responsibility as a key aspect of their overall governance role and are, by law, directly accountable to the Victorian Minister for Health. However, effective clinical governance is everyone’s business.

Clinical governance is not about compliance. High-performing health services achieve great outcomes by taking actions that go beyond compliance. These include (Hamet al. 2016):

- **a vision for the future** – clearly communicated, specific and quantifiable goals for improving care
- **consumer partnerships** – the consumer is at the centre of care and viewed as a critical partner in the design and delivery of healthcare
- **organisational culture** – a ‘just’ culture exists whereby health service staff are supported and their wellbeing prioritised
- **continual learning and improvement** – health service staff are provided with opportunities and encouragement to further their skill set and qualifications

“To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.”

Sir Liam Donaldson
World Health Organization Envoy for Patient Safety
• **Clinical leadership** – strong, transparent, supportive and accessible leadership fosters a culture of learning, accountability and openness, with strong clinical engagement

• **Teamwork** – staff are supported at all levels of the organisation by skilled management

• **Quality improvement** – established methods and data are used to drive and design actions to improve safety and quality.

(The term ‘consumer’ includes patients, clients, residents, families, carers and communities.)

The content in this updated clinical governance framework reflects the current literature on high-performing health services and best practice in clinical governance. There is a renewed and strengthened emphasis on leadership, culture and improvement as being fundamental to high-quality care. The framework identifies the systems required to develop and maintain a high performing organisation.

The systems are organised into five domains and underpinned by continuous monitoring and improvement:

• leadership and culture

• consumer partnerships

• workforce

• risk management

• clinical practice.

The framework has been designed so that health services can adapt and implement its components to best meet the needs of their consumers and organisation. It is important that governance systems do not remain static but that they are regularly reviewed and evaluated to meet local requirements and drive continued improvement. It is critical that every member of the organisation—board, management, clinical, administrative, ancillary—understands that they have a role in pursuing excellence.

For the purposes of this framework, high-quality care is defined as:

• **Safe** – avoidable harm during delivery of care is eliminated

• **Effective** – appropriate and integrated care is delivered in the right way at the right time, with the right outcomes, for each consumer

• **Person-centred** – people’s values, beliefs and their specific contexts and situations guide the delivery of care and organisational planning. The health service is focused on building meaningful partnerships with consumers to enable and facilitate active and effective participation.

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CRANAplus 2013
The following principles should guide effective clinical governance systems.

**Clinical governance principles**

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<th><strong>Excellent consumer experience</strong></th>
<th>Commitment to providing a positive consumer experience every time</th>
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| **Clear accountability and ownership** | Accountability and ownership displayed by all staff  
Compliance with legislative and departmental policy requirements |
| **Partnering with consumers** | Consumer engagement and input is actively sought and facilitated |
| **Effective planning and resource allocation** | Staff have access to regular training and educational resources to maintain and enhance their required skill set |
| **Strong clinical engagement and leadership** | Ownership of care processes and outcomes is promoted and practised by all staff  
Health service staff actively participate and contribute their expertise and experience |
| **Empowered staff and consumers** | Organisational culture and systems are designed to facilitate the pursuit of safe care by all staff  
Care delivery is centred on consumers |
| **Proactively collecting and sharing critical information** | The status quo is challenged and additional information sought when clarity is required  
Robust data is effectively understood and informs decision-making and improvement strategies |
| **Openness, transparency and accuracy** | Health service reporting, reviews and decision-making are underpinned by transparency and accuracy |
| **Continuous improvement of care** | Rigorous measurement of performance and progress is benchmarked and used to manage risk and drive improvement in the quality of care |

Sir Liam Donaldson, speaking at the Conference on the Development of Surgical Competence on Clinical Performance and Priorities in the NHS, November 1999
Clinical governance roles and responsibilities

In order to achieve consistently safe and high-quality care, the following critical elements of the five domains apply to every employee within Victorian health services:

- commitment to partnering with consumers to facilitate effective engagement and participation
- ownership and accountability for the quality and safety of the care provided
- regular evaluation of performance to identify areas for improvement.

In addition to these responsibilities, every member of a health service (clinical and non-clinical alike; see Figure 1) has specific responsibilities regarding achieving and maintaining high-quality and safe care.

Figure 1: Clinical governance roles
The Victorian Government (Department of Health and Human Services, Safer Care Victoria and Victorian Agency for Health Information) has a number of key clinical governance responsibilities including:

- setting expectations and requirements regarding health service accountability for quality and safety and continuous improvement
- ensuring health services have the necessary data to fulfil their responsibilities, including benchmarked and trend data
- providing leadership, support and direction to ensure safe, high-quality healthcare can be provided
- ensuring board members have the required skills and knowledge to fulfil their responsibilities
- proactively identifying and responding decisively to emerging clinical quality and safety trends
- effectively monitoring the implementation and performance of clinical governance systems, ensuring the early identification of risks and flags
- monitoring clinical governance implementation and performance by continually reviewing key quality and safety indicators.

Consumers are at the centre of clinical governance and should:

- participate in their own healthcare and treatment, and that of their family and carers, to their desired extent
- participate in system-wide quality and safety improvement
- partner with healthcare organisations in governance, planning and policy development to co-design and drive improvement in performance monitoring, measurement and evaluation
- advocate for patient safety to support the best possible treatment and outcomes for themselves and others
- provide feedback, ideas and personal experience to drive change.

Health service boards are accountable for the safety and quality of care provided by their service, with key responsibilities being:

- performing as a discrete entity accountable to the Victorian Minister for Health and ultimately being accountable for the quality and safety of the care provided by the organisation
- setting a clear vision, strategic direction and ‘just’ organisational culture that drives consistently high-quality care and facilitates effective employee and consumer engagement and participation
- staying engaged, visible and accessible to staff
- ensuring it has the necessary skill set, composition, knowledge and training to actively lead and pursue quality and excellence in healthcare
- understanding key risks and ensuring controls and mitigation strategies are in place to mitigate them
- monitoring and evaluating all aspects of the care provided through regular and rigorous reviews of benchmarked performance data and information
- ensuring robust clinical governance structures and systems across the health service effectively support and empower staff to provide high-quality care and are designed in collaboration with staff.
• delegating responsibility for the implementation, monitoring and evaluation of clinical governance systems to the CEO and working in partnership with the CEO to realise the organisation’s vision
• regularly seeking qualitative and quantitative information from the CEO, executive and clinicians about the status of the quality and safety of care processes and outcomes in all services.

The health service CEO is responsible for:
• providing visible leadership and commitment in delivering and supporting the strategic direction set by the board
• creating a safe and open culture that empowers staff to speak up and raise concerns
• working in partnership with the board to ensure efficient allocation of resources that achieve public value and deliver on the organisation’s vision for quality and safety
• equipping staff to fulfil their roles by providing role clarity at each level of the organisation along with
• the necessary knowledge, tools, resources and opportunities to engage and influence the organisation’s core business
• elevating quality of care within the organisation, ensuring the voice of the consumer is at the centre of core business and that the organisation remains focused on continuous improvement
• fostering a ‘just’ culture of safety, fairness, transparency, learning and improvement in which staff are empowered and supported to understand and enact their roles and responsibilities
• delegating the implementation, review, measurement and evaluation of operational quality and safety performance to executive and clinical leaders
• regularly reporting to the board with internal and external data on clinical risks, care processes and outcomes, areas for improvement and progress towards excellence across all clinical services
• proactively seeking information from qualitative and quantitative sources, including the voice of the consumer and clinician, to paint a comprehensive picture of the quality of care and services
• adopting a ‘no surprises’ partnership approach with the board in the pursuit of excellence and welcoming questions that may help identify important issues or blind spots.

The health service executive has a clearly defined role in clinical governance including to:
• lead and support the health service to deliver the board’s vision for safe, quality care, facilitating and ensuring effective staff and consumer involvement
• develop and support safety and quality leaders in their services and provide assurance to the CEO that staff at each level of the organisation are supported to actively pursue high-quality care for every consumer
• ensure robust and transparent reporting, analysis and discussion of the safety and quality of care occurs regularly and is informed by qualitative and quantitative data, committee structures and clinician engagement
• understand and monitor the areas of key risk and ensure escalation and response actions are taken where safety is compromised
• regularly evaluate clinical governance systems to ascertain their effectiveness.

1 This information should be sought beyond the purposes of audit and accreditation.

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Clinical leaders/managers within a health service are required to:

- understand the challenges and complexity of providing consistently high-quality care and support clinicians through a culture of safety, transparency, accountability, teamwork and collaboration
- provide a safe environment for both consumers and staff that supports and encourages productive partnerships between different clinical groups and between clinicians and consumers
- provide useful performance data and feedback to their clinicians and relevant committees and engage clinicians in identifying and taking appropriate action in response
- actively identify, monitor and manage areas of key risk and lead appropriate escalation and response where safety is compromised
- be skilled in staff management, foster productive and open cultures, and promote multidisciplinary teamwork
- ensure staff are clear about their roles and responsibilities, are supported with resources, standards, systems, knowledge and skills development, and hold them to account for the care they provide
- expect and drive action in response to managing risks and improving care.

All health service staff should:

- provide high-quality care in their services as a priority
- go beyond compliance to pursue excellence in care and services
- speak up and raise concerns and issues, promoting a culture of transparency
- share information and learnings regarding clinical safety
- regularly update their skills and knowledge to provide and support the best care and services possible
- actively monitor and improve the quality and safety of their care and services
- work with care standards and protocols
- contribute to a culture of safety, transparency, teamwork and collaboration.
Part 2: Domains and systems

Within the five domains, key systems and practices are required to support safe, effective, person-centred care for every consumer, everytime.

The five domains of clinical governance are interrelated (see Figure 2) and should be integrated into the organisation’s broader governance arrangements (for example, clinical risk management is a component of broader risk management).

It is expected that health services tailor and implement these components to support consumers and staff to work together to achieve high-quality care.

Figure 2: Clinical governance domains
Leadership and culture

High-quality healthcare requires engaged clinicians and patients.

Visible, accountable and purposeful leadership at all levels of a service is required to cultivate an inclusive and just culture that will make engagement a reality. Engaged staff and consumers who actively participate in organisational strategy, planning and delivery are the origins of quality.

Some signs of success

Staff survey response rates exceed 40 per cent

Staff report that a ‘just’ culture exists within the health service

There are high rates of agreement with safety culture questions in the People Matter survey

Leaders conduct regular walkarounds and ask staff and patients questions related to the safety, effective and person-centred care being experienced and delivered

The board and executive lead and regularly discuss progress with a plan to achieve a set of strategic goals and priorities for safe, effective and person-centred care

There is consumer representation on board quality committees

Culture doesn’t just happen; it is purposeful. A strong organisational culture is required to support leaders and staff to create and maintain high-quality care. The culture should be one of fairness, respectfulness and transparency. It should be based on principles of natural justice, innovation, learning from errors and accountability for decisions and behaviours.

Creating and maintaining this culture and achieving this strategic goal requires effort, robust systems and productive working relationships between boards, CEOs, the executive, consumers, clinical leaders and all staff. These relationships support and challenge each group to achieve a shared vision for excellence in the safety and quality of care. Culture is organisation wide, not craft group or workplace specific.

ensure:

• a clear vision for improving the quality of care is developed and communicated
• there is organisational alignment in achieving strategic goals and priorities for providing high-quality care for every consumer in a way that is seamless and integrated
• there is a supportive, transparent culture, set and led by the board that assists all health service staff to provide high-quality care and continuously improve
• clear accountability is assigned for planning, monitoring and improving the quality of each clinical service
• the CEO, board and clinical leaders regularly discuss where the health service is positioned in relation to peer health services and seek external ideas and knowledge on how best to strive for high-quality care
• the board and executive visibly engage with and support consumers, clinicians, managers and staff in their roles
• appropriate governance structures, including committee and reporting structures, are in place to effectively monitor and improve clinical performance

Systems must be in place to

Delivering high-quality healthcare

2.2 Victorian Clinical Governance Framework / 72
• there is development and support at all levels of the organisation of leaders who promote and drive high-quality care
• staff skills and systems for achieving high-quality care and for managing change and improvement are developed across the organisation
• the organisation’s safety culture is regularly measured to identify areas of success and issues for improvement, including staff understanding at all levels of their role in creating safe care
• there is regular and rigorous evaluation of the effectiveness of systems for developing and supporting positive organisational leadership and culture.

Consumer partnerships

Healthcare is all about the consumer. Consumer experience and participation (among patients, clients, residents, families, carers and community members) are crucial indicators of quality and safety.

Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement. Lifting and responding to the consumer voice is at the origin of good clinical governance.

Empowering consumers to partner in care and decision-making enables staff to better understand the individual consumer’s specific needs, concerns and values. It supports staff in providing more appropriate treatment and care plans and leads to better clinical and patient outcomes. Consumer feedback, both positive and negative, is a valuable resource and should be encouraged in all aspects of the service. Complaints should be responded to in consultation with the consumer to reach suitable resolutions; outcomes should then be used to drive improvement.

Partnering with consumers is a cornerstone of healthcare delivery and the key contributor to achieving the organisation’s strategic goals. Consumer partnerships should be promoted across the organisation in planning, policy development, guidelines, training and care delivery.
**Some signs of success**

Being able to identify changes made in response to complaints or feedback from an active consumer advisory committee whose members are trained and supported

- Consumer-led patient walkarounds

- Positive patient survey feedback, particularly on questions relating to information and involvement

- Shared understanding of established goals relating to patient outcomes

- A clear consumer advisor governance framework is in place that supports open and efficient reporting of advisor concerns to the executive and board

- Consumer representatives on board quality committees feel they are making a useful and respected contribution to improving care

- Consumers are encouraged and equipped to participate in organisational strategy and decision-making for care improvement

Systemsshould be in place to ensure:

- consumers and their needs are key organisational priorities

- consumers are actively invited to provide feedback on their experiences of care consumers are provided with the relevant skills and knowledge to participate fully in their care to the extent they wish

- consumers are provided with the opportunity, information and training to fully participate in organisational processes for planning, monitoring and improving services

- clear, open and respectful communication exists between consumers and staff at all levels of the health system

- services respond to the diverse needs of consumers and the community

- services learn from and act on the feedback on clinical care and service delivery as provided by consumers in order to make improvements

- the rights and responsibilities of consumers are respected and promoted to the community, consumers, carers, clinicians and other health service staff, as required by the Australian Charter of Healthcare Rights (ACSQHC 2008) (see also *The Australian Charter of Healthcare Rights in Victoria* brochure)

- consumer participation processes are monitored for their effectiveness in empowering consumers to fully partner in their care

- complaints are responded to compassionately, competently and in a timely fashion, with feedback provided to all parties about the action resulting from their input

- issues arising from complaints are analysed, reported and used to improve care and services

- the systems for empowering meaningful consumer participation are regularly and rigorously evaluated.
Workforce

Systems are required to support and protect a skilled, competent and proactive workforce. This requires comprehensive strategies and plans for recruiting, allocating, developing, engaging and retaining high-performing staff. These strategies will ensure the health service has the right people with the right skills at the right time to provide optimal care.

Providing a physically and psychologically safe workplace is fundamental to achieving a high-performing workforce and for addressing workplace bullying. Organisational planning and resource allocation must involve effective staff engagement.

Staff at all levels of the organisation require access to training and information about effective change and about improvement tools and methods. Staff should be supported to apply these tools and methods to review and improve their practice. Proactive human resources systems should support staff to develop and consolidate their skill base, work within their scope, provide supervision where required and manage performance.

Systems should be in place to ensure:

- planning, allocation and management of the workforce provides the appropriate personnel and skills to deliver high-quality care and to meet changing consumer needs
- the healthcare workforce has the appropriate qualifications and experience to provide high-quality care and ongoing professional development to maintain and improve skills
- a safe and fair workplace based on a 'just' culture and mutual respect is provided, with systems in place to address issues with culture such as workplace bullying
- promotion and support of multidisciplinary teamwork is the basis of providing high-quality care
- clear communication of role expectations, responsibilities and standards of performance is provided to all staff, and employees are supported and held accountable for meeting these expectations
- mentoring and supervision is used to support, monitor and develop clinical staff
- training and tools are provided so staff can monitor and improve their own practice and organisational processes more broadly

Some signs of success

Staff engagement and satisfaction is measured and is a priority area of focus for the board

The training and development budget is fully utilised

Staff orientation and induction includes quality and safety issues

There are high levels of participation in employee performance reviews and professional development planning

There is a system for ensuring that critical clinical training requirements have been met

Resource planning and allocation provides for effective staff supervision and mentoring
• innovation in workforce practice supports the development and maintenance of workforce excellence
• there is a just process for addressing individual performance that prioritises consumersafety
• a defined system for managing complaints or concerns about a clinician is in place and is regularly reviewed for its effectiveness
• the systems for developing and supporting the workforce are regularly and rigorously evaluated to ensure their effectiveness in supporting high-quality care.

Some signs of success

Quality and safety outcomes are monitored against external benchmarks
Trending analysis of data is conducted
Documented review of risks and mitigation actions are reported to the board at least quarterly
Performance regarding safety culture is reviewed
The board receives regular reports regarding the progress on achieving organisational goals for safe, quality care for every consumer
Trended and analysed risk and improvement data are used by the board and executive to make decisions about improvement
The organisation’s safety culture is measured and strategies are implemented to improve

Risk management

Minimising and safeguarding against clinical risk requires a structured approach to safety that is both proactive and reactive—prevention and repair. Consistently safe practice is built on staff awareness and knowledge. It is supported by robust systems that prioritise safety.

Effective systems support staff to identify and respond appropriately when things go wrong.

Clinical risk management strategies and processes must be integrated with broader governance within the health service to rigorously identify, monitor, review and mitigate risk. Risk identification and treatment strategies must be frequently reviewed to ensure early identification of trends in risk across all clinical services. Where safety is compromised, leadership and risk systems must support staff to initiate appropriate and timely escalation, management and corrective action. It is essential that all issues related to risk are subsequently analysed in order to inform future practice and improve safety.

Systems should be in place to ensure:
• a planned, proactive, systematic and ongoing evidence-based approach to creating safety for consumers and staff is in place
• the organisational culture supports staff to pursue safe practice and to speak up for safety
• risk considerations and data inform goal and priority setting and the development of business and strategic plans
• clinical processes, equipment and technology are designed to minimise error and support clear, unambiguous communication between staff.
• risks are proactively identified, monitored and managed through an effective register with clearly understood, integrated risk data
• known clinical risks are proactively addressed and all services are regularly scanned to identify risks as they emerge
• identification and reporting of clinical incidents is consistent with the requirements of the Victorian Health Incident Management System (VHIMS) and is tracked over time to monitor and identify safety issues
• clinical incidents are investigated to identify underlying systems issues and root causes, and this information is used to improve safety
• open disclosure processes are in line with the Australian open disclosure framework (ACSQHC 2013)
• the service complies and adheres with risk-related legislation and relevant Australian standards
• systems and datasets for developing and supporting clinical risk management are regularly and rigorously evaluated to ensure their effectiveness in supporting high-quality care.

Clinical practice

Good clinical practice requires systems that support clinicians to provide safe and appropriate care for each consumer with the best possible outcome, working within the clinical scope of the organisation.

Clinical practice should strive for patient-centred, cohesive, integrated care at all times along the care continuum. It should ensure a shared understanding of the care pathway and goals between clinicians and consumers.

Systems for clinical practice effectiveness should ensure clinicians have the required knowledge and skills, technology and equipment to provide the best care possible. Clinicians must also be supported and expected to regularly and rigorously review their practice, to embrace peer review and teamwork, and to contribute their knowledge and experience to improving care.

These safety, effectiveness and appropriateness of care should be regularly reviewed using appropriate measures and reporting mechanisms.
Some signs of success

Clinical services actively participate in relevant clinical registries and clinical audit activities.

Benchmarked and trended information about the clinical effectiveness of services is available to and used by clinicians and by the board.

Publicly available data about performance on a range of outcome measures (such as pressure injuries and hospital-acquired bacteraemia) is displayed in the health service.

Clinicians are working within their approved credentialling and scope of practice requirement.

Research and evidence should form the basis of care provision, in tandem with appropriately credentialled, experienced and competent staff. Clinicians at all levels of the organisation should have access to training and information about effective change and improvement tools and methods, and be supported to apply them to review and improve their practice.

Variations in clinical quality and clinical practice will occur within the complexity of healthcare; these should be actively monitored and discussed in light of what is best for the consumer. As with clinical governance itself, clinical practice is not ‘set and forget’. It must be closely monitored and regularly reviewed, evaluated and evolved in line with emerging evidence/technologies and changing consumer needs.

Systems should be in place to ensure:

- evidence-based clinical care is delivered within the clinical scope and capability of the health service
- evidence-based clinical care standards and protocols are clearly articulated, communicated and adhered to across the organisation
- clinicians regularly review and improve clinical care, preferably in a multidisciplinary manner
- credentialling, scope of practice and supervision processes support clinicians to work safely and effectively within their scope of practice
- active clinical partnerships are developed with consumers and include a shared understanding of the care plan
- consumers are transitioned across care settings and services smoothly
- clinicians participate in the design and review of clinical systems and processes, and support clinical innovation
- data on the safety, clinical effectiveness and person-centredness of care is collected, analysed and shared for the purposes of both accountability and improvement
- clinical care processes and outcomes are measured across all services
- clinicians regularly review their own performance
clinicians lead activities to improve clinical practice, and these activities are planned, prioritised, supported by change and improvement science, and are sustainable

clinical practice variation is closely monitored and regularly reviewed to ensure quality outcomes for high-risk, high-volume and high-cost services

there is a ‘just’ process for addressing issues with individual clinician performance that prioritises consumer safety

clinical quality improvement activities undergo external reviews

new procedures and therapies are introduced in a way that ensures quality and safety issues have been identified

clinical practice is regularly and rigorously evaluated to ensure its effectiveness in supporting high-quality care

appropriate utilisation of healthcare is monitored and reviewed as a component of quality.
Critical clinical governance questions

- How do we know our care is safe and effective?
- How do we ensure the quality and safety of care?
- Do we know what the red flags are?
- How will we fix what we know isn’t working?
- What needs to get done to improve the quality and safety of care?
- Do we have a ‘just’ culture to facilitate continuous improvement in quality and safety?
- What actions do we take as a group to ensure that intimidating and inappropriate behaviour is not tolerated?
- What actions do we take to ensure patients are empowered to meaningfully partner in their care and the organisational design of the service?
- Are we frequently evaluating the impact and extent of the patient voice?
- How effective are our organisational governance systems in supporting our safe, effective and person-centred goals for every consumer?
- What must we do to increase the effectiveness of our systems?
- Do all staff feel supported to create consistently safe, person-centred and effective care?
- What must we do to increase support for staff?
- Are our clinicians adequately skilled, engaged and empowered to provide safe, high-quality, person-centred clinical care?
- Are we achieving our purpose of providing a safe, person-centred and effective experience for every consumer? What must we do to make more progress on achieving our purpose?
- Where is the evidence that our patients are better off?
- Do we have a shared definition/understanding of success?
Symptoms of clinical governance failure

A number of common themes have emerged from reviews of healthcare organisations that have experienced high-profile failures in patient care:

- An institutional, isolated and inward-looking culture that is unsupportive of learning and that develops and cultivates a fear of speaking up.
- A disengaged board, CEO and executive who are unwilling to hear bad news.
- Clinical leaders who are disconnected from the organisation’s clinical governance processes and systems.
- Lack of clinical leadership, staff engagement and teamwork to support safe, high-quality care.
- Weak reporting format and content, particularly a lack of benchmarking and trend analysis, and a passive monitoring response.
- A quality system based on compliance with standards with limited service and care improvement beyond the requirements of the standards.
- A lack of robust review of clinical practice and an assumption that monitoring, performance management or intervention is ‘someone else’s responsibility’.
- Tolerance of substandard care—problems are long-standing and known by many stakeholders but not actively addressed.
- A lack of consumer participation and input and limited interest in consumers and their families—decisions are made in the interests of the organisation and staff over the safety and quality of patient care.
Part 3: Additional information – references and acknowledgements

Additional information

The Victorian Government will provide supportive and adaptive leadership and set a clear vision of excellence for Victorian health services. In striving for continuous improvement and achieving the recommendations set out in the Targeting zero: the review of hospital safety and quality assurance in Victoria report, the government will implement new approaches to building and addressing clinical capability. This goal is underpinned by the commitment to delivering a person-centred healthcare system and improving quality and safety across Victoria.

The Department of Health and Human Services is intensifying its efforts as the system leader and manager and increasing the focus on leading and coordinating: health system design and planning; policy development and implementation; and funding design. The department will work with rural and regional health services to improve collaborative clinical governance arrangements. In addition, the strengthened oversight and engagement processes will enable the department to act quickly and decisively to address quality and safety risks and to facilitate more effective information sharing with and between health services.

Safer Care Victoria will lead quality and safety improvement across Victorian health services — public and private — by providing support via a range of new quality and safety programs and utilising the experiences of frontline clinicians through vitalised clinical networks and the establishment of the Victorian Clinical Council. Together with the department, Safer Care Victoria is developing tools, resources and clinical governance training programs for clinicians, board members and management to supplement this framework and to assist health services in its implementation. These will continue to be refreshed to ensure utility and relevance.

The Victorian Agency for Health Information is committed to expanding relevant quality and safety datasets available to health services and improving timeliness and accessibility. Standardised benchmarking reports will also be provided to health services to drive improvements to safety and quality and to better assess and improve clinical governance performance and processes.
References and further reading

- Australian Commission on Safety and Quality in Health Care (ACSQHC) 2012, National Safety and Quality Health Service (NSQHS) Standards, ACSQHC, Sydney.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) 2015, Guide to the National Safety and Quality Health Service Standards for health service boards, ACSQHC, Sydney.
- CRANAplus 2013, Clinical governance guide for remote and isolated services in Australia, CRANAplus, Alice Springs.
Acknowledgements

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- Mr Nick Bush
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- Ms Vicki Farthing
- Mr Michael Gorton AM
- Mr Alan Lilly
- Ms Bernadette McDonald
- Dr Liz Mullins
- Mr Shane Thomas
- Dr Michael Walsh
- Dr Margaret Way.
Useful references

- CRANAplus, Clinical governance guide for remote and isolated services in Australia, (2013) CRANAplus, Alice Springs.
- Stepnick, Larry, Maximizing the Effectiveness of the Board’s Quality Committee: Leading Practices and Lessons Learned, (Fall 2015), The Governance Institute (White Paper).
- Appendix 8 – Clinical reports example
3. Conduct, ethics and fiduciary duties

Boards and their directors are integral to the running of Victoria’s health services. Directors are representatives of the Victorian Government. How directors conduct themselves reflects on the board, the health service, DHHS and the Minister.

Health service board directors are therefore expected to uphold the highest standards of integrity and conduct and act in accordance with their responsibilities and obligations.

Questions that directors of health services should ask

- Do I always act in the best interests of the health service?
- How well do I understand the concept of ‘conflict of interest’?
- Are perceived, potential or actual conflicts discussed and declared regularly?
- Do I have a clear understanding of what constitutes confidential information and how it must be treated in and out of the boardroom?
- Does the board have its own code of conduct and compliance program? How often are these programs reviewed to determine if they need updating in accordance with DHHS, organisational, policy, legal and/or regulatory changes?
- Has the board’s ethics and compliance program been reviewed by outside consultants or experts for improvement opportunities?
- Does the board have an effective process in place that allows for a protected disclosure?
- Do employees receive the information required to understand the health service’s core values, code of ethics and conduct, policies, and laws and regulations related to their jobs?
- Do the executive and senior management fully inform the board about perceived, potential or actual conflicts between the health service’s values and the organisational practices of the services it operates?
- Are there processes and practices in place to promote ethical behaviour and do they align with VPSC requirements?
- How does the board manage disputes/grievances?

Red flags

- Directors do not understand that they are public officials and what this means.
- Directors sometimes make decisions that benefit individuals and/or the local community rather than the health service.
- Obligations such as management of conflicts of interest, development of the health service’s by-laws, maintaining clinical standards of care and meeting privacy requirements are not known or well understood by directors.
- Directors do not know of or understand the VPSC’s Director’s Code of Conduct.
• There are an unusual number of internal and external complaints.
• The board receives no reports or information regarding protected disclosure policy.
• The board does not ask questions related to ethics or conduct.
• A board director is claiming expenses that are not reasonable.
• Directors communicate inappropriate or confidential content to the local community, the press and/or social media.
• Directors fail to meet their fiduciary duties, enshrined in law, to act in the best interest of the health service (which includes governing the health service in accordance with the Minister’s policy directives).

Introduction to the chapter

All board directors are expected to lead by example in relation to behaviours, for example, adopting the organisation’s values, respecting confidentiality and encouraging discussion. This chapter:

• provides information and guidance in relation to the binding provisions of the PAA and VPSC’s Director’s Code of Conduct21 (applicable to all Victorian public sector directors), which includes conflicts of interest, expenses and proper use of information
• provides practical examples of how to apply the Directors’ Code of Conduct
• introduces the concept of ‘fiduciary duties’, which are common law duties, and what that means for individual directors and boards collectively, especially in relation to conduct, behaviour and ethics.

The binding obligations on directors

Conduct is more than just adherence to rules and policies. Conduct should embed an ethical code into an organisation.

Every director of Victoria’s public entities are public officials and are bound by the obligations outlined in the PAA.22

The PAA sets out the importance of maintaining public sector professionalism and integrity and charges the VPSC with preparing and issuing a code of conduct based on the public sector values.

The VPSC’s Director’s Code of Conduct also sets the standard of behaviour expected of directors. These behaviours are essential to how directors perform their duties, the relationships they have with each other and the relevant portfolio Minister, departmental and public entity staff, and the community. It details the expected levels of behaviour, integrity, transparency and independence of directors. These elements are integral to upholding the values of the PAA and are critical in assisting directors to fulfil their obligations and duties. The Director’s Code of Conduct also forms one of the key measures of director performance. Failure to follow the Director’s Code of Conduct will impact on an individual’s opportunity for appointment or reappointment to a public entity board.


22 Please see sections 4 and 5 of the Public Administration Act 2004 (Vic) for the definitions of ‘public entity’ and ‘public official’.
Public sector values

Section 7 of the PAA sets out those obligations and duties and requires public officials, including directors, to demonstrate the following seven public sector values:

1. **Responsiveness** - frank, impartial and timely advice to the Government; high quality services to the Victorian community; identification and promotion of best practice
2. **Integrity** - be open and transparent in your dealings; use power responsibly; do not place yourself in a position of conflict of interest or seek undue advantage for yourself (or others); strive to earn and sustain a high level of public trust
3. **Impartiality** - avoid bias (conscious and unconscious), discrimination, impulse or self-interest; demonstrate respect for others by acting in a professional and courteous manner
4. **Accountability** - accept responsibility for your decisions; do not engage in activities that may bring you or the entity into disrepute; work to clear objectives in a transparent manner
5. **Respect** - demonstrate respect for fellow board directors, colleagues, other public officials and members of the Victorian community by treating them fairly and objectively; ensuring freedom from discrimination, harassment and bullying; using their views to improve outcomes on an ongoing basis
6. **Leadership** - promote and support the application of the Victorian public sector values; act in accordance with the Director’s Code of Conduct
7. **Human rights** - public officials should respect and promote the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006 (Vic)*, make decisions and provide advice consistent with human rights; actively implement, promote and support human rights.

Case study - accountability

Bethany is the CEO of Better Care Services (BCS). She has just attended the BCS board meeting at which the board had requested she present on a key strategic outcome - improving emergency department wait times.

The project to support this was to implement an access triaging method/algorithm. The project has not been going to plan and, although a project plan was in place, staff are disengaged with the new algorithm and continue to use the old method. Recent surveys and statistics depicted no improvement in wait times.

Bethany was honest with the board and stated the outcome was not progressing as expected or forecast. She explained some of the challenges she and her team were facing with staff uptake of the new algorithm and provided various options for the board to decide on to get the project back on track.

Individual integrity and ethical conduct

Good governance is ultimately about personal and organisational integrity. Ethics is about honesty, integrity, trust, accountability, and transparency.

This is why ethical conduct is a key factor in the long-term viability and success of health service organisations.

The reputations of individual directors and executives are tarnished when a health service is seen not to have acted ethically, or has otherwise breached community standards.

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Behaviours expected of the board and the individual

The Director’s Code of Conduct enhances and expands upon these values and outlines the expected behaviour of the board and individual directors.  

Responsibilities of the board

**Leadership and stewardship** – the board safeguards and oversees the management of the health service, focusing largely on strategic issues, risk management and engagement with stakeholders. The board does not get involved in implementation and operations; this is the remit of the CEO and executive team.

**Board authority and delegation** – the board clearly defines matters that are reserved for board discussion and approval, ensuring that any necessary delegations to management or sub-committees are documented, communicated and in place. The board is accountable for the actions of its delegates/sub-committees.

**Best interests of the public entity** – the board acts consistently with the functions and objectives of the health service, such as its SoP and any other similar documents.

**Risk management and financial responsibility** – the board oversees the management of risk so as to ensure that the health service is financially viable. This includes ensuring a robust financial management system is in place. The board informs the portfolio department and Minister of known major risks to the effective operation of the health service.

**Conflicts of interests and duty** – the board manages actual, potential and perceived conflicts of interest with directors restricting their involvement in a matter, stepping down from their position or relinquishing their private interest where applicable.

‘Walking the talk’

‘Walking the talk’ is about embedding the principles within the Director’s Code of Conduct throughout the organisation.

When overseeing the implementation of the Director’s Code of Conduct, directors must ensure it is effectively communicated by management. The board should make certain that the Director’s Code of Conduct is taken seriously throughout the organisation, and breaches will give rise to disciplinary measures (both internally and externally).

Merely issuing the Director’s Code of Conduct does not ensure it will be observed. To add value, it must extend beyond a compliance focus and strive to cultivate and maintain an organisation that focuses on positive moral behaviour while simultaneously striving to prevent ethical lapses.

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The Director’s Code of Conduct will continually evolve with the changing environment, which includes adapting to changes in laws and regulations, the operational environment, public opinion and the focus on acceptable organisational behaviour. Those health services developing or revising their internal code of ethics and conduct should consult frequently with DHHS and VPSC.

Responsibilities of individual directors

**Duties of the chair** – presiding over meetings and ensuring policies, processes and behaviours are upheld.

**Leadership and stewardship** – lead by example and promote public sector values through their own behaviours.

**Complying with establishing legislation and board policies** – comply with all relevant legislation, regulations, by-laws, policies and procedures that apply to the health service. This includes the Victorian Government’s and Minister’s policies and priorities.

**Care, diligence and skill** – exercise powers with reasonable care, due diligence and skill; ensuring that only relevant information is sought and considered.

**Best interests of the public entity** – the health service always comes first. Directors must act in the best interests of the health service and must not allow personal and/or professional interests/relationships to influence their judgement.

**Proper use of position** – directors use their position to promote the best interests of the health service. Directors must not seek advantage for themselves and/or others or cause detriment to the health service.

**Proper use of information** – all information provided to directors is only used only for the purpose it was intended. Directors do not use information (e.g. privileged or commercially sensitive) to obtain an advantage for themselves and/or others or cause detriment to the health service. Confidentiality is respected at all times and information is not ‘leaked’.

**Standing for election** – directors notify the board of any intention to stand for any election (state, federal or local level), which is promptly relayed to DHHS.

**Fairness and impartiality** – directors behave in a manner that is free from favouritism, self-interest, bullying and/or intimidation in all dealings.

**Financial responsibility** – directors exercise care in relation to public funds and comply with the Standing Directions of the Minister for Finance and the rules of the Financial Management Compliance Framework.

**Honesty and integrity** – directors act with honesty and integrity and comply with all laws, policies and generally accepted standards of behaviour.

**Conflicts of interest and duty** – directors avoid actual, potential and perceived conflicts of interest. If a conflict arises, they declare and manage the conflict in accordance with the guiding policies and processes in place.
Conflicts of interest

What is a conflict of interest?
A conflict of interest is where a director has interests that could influence, or be seen to influence, their decisions or actions in the performance of their duties.

Conflicts of interest and duty may be actual, potential or perceived.

Why does it matter?
Conflicts of interest are frequently referenced in public sector governance and public settings due to the trust and confidence reposed on the director. Public sector agencies like health services have significant investment and faith placed in them by the public. Avoiding, and where this is not possible, declaring and managing a conflict is critical for the public to maintain their trust and confidence in the health service as an entity. For this reason, no decision maker in the entity – be they the board, the CEO or even a low level procurement officer, can have a conflict of interest regarding the decision being made.

For directors and senior management, this duty is more onerous, where the duty to broader to avoid any conflict that would cause a reasonable person to doubt if you put the health service interests first.

Fiduciary duties are further discussed later in this chapter.

Actual conflict of interest
There is a conflict between a director’s public duties to the health service and private interests or other public duties.

Case study 1: Nurses R Us
John is a board director of Better Health Service. He is also a director of ‘Nurses R Us’, a specialist employment agency that provides nurses to health services.

The health service has a high nurse turnover and urgently requires nurses to fill those vacant full time positions. Permanently filling the roles will take a number of months due to the length of the advertising, shortlisting and hiring processes. During the interim period, the health service must hire agency nurses.

John suggests the health service use ‘Nurses R Us’. The board believes they can trust the agency as it is more of a known quantity because they know and trust John. The board agrees with John’s recommendation and enters into an agreement with ‘Nurses R Us’.

This is an actual conflict as a decision has been made that directly benefits John’s private interests.
Potential conflict of interest

A director has interests that could conflict with their duties.

This type of conflict also encompasses circumstances where it is foreseeable a conflict may arise in future.

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**Case study 2: Tendering**

Janice is the chair of the Better Care Service board; she is also a director of a large construction company. The health service has been having infrastructure issues for a number of years and requires refurbishment. The board has decided to tender for the refurbishment works.

The chair has a potential conflict of interest and needs to be cautious when discussing and/or making decisions with respect to the refurbishment of the hospital.

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Perceived conflict of interest

The public or a third party could form the view that a director’s interests could influence their decisions or actions, now or in the future.

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**Case study 3: Family benefits**

Rose is a former board chair of Better Care Services (BCS) and her family is well known in the community. Her daughter, Jasmine, is interested in applying for a director role on the board of BCS. Rose arranges for the current BCS chair to have a coffee meeting with Jasmine in the local coffee shop and give her an insight into what the board does and the appointments process.

Jasmine subsequently applies for a director role, goes through the appropriate due process, and is appointed to the board by Governor-in-Council on recommendation of the Minister.

This is a perceived conflict of interest. The public knows Steven’s family, including Jasmine, and seeing her sit down with the current chair, and subsequently being placed on the board, is likely to cause a reasonable bystander/outsider to believe the appointments process has been influenced.
Conflict of duty

A conflict of duty arises when a person is required to fulfill two or more roles that may actually, potentially or be perceived to be in conflict with each other. For example, a director may hold a director position on a health service and also hold a position as a member of another public board. A conflict of duty may also arise through a director having official duties to other Commonwealth and local government bodies, community and professional associations or non-governmental organisations.

Conflict of duty scenarios are especially common in regional and rural settings due to the smaller size of communities. It is not always possible to avoid a situation where a conflict of duty exists, particularly in small communities, or some specialist industries. However, it is vital that these situations are managed appropriately to ensure the public interest is protected.

The following table provides numerous examples to assist in identifying conflicts of interest and duty.

<table>
<thead>
<tr>
<th></th>
<th>Conflict of interest</th>
<th>Conflict of duty</th>
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<tbody>
<tr>
<td><strong>Actual</strong></td>
<td></td>
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</tr>
<tr>
<td>Financial</td>
<td>Director is a partner in a business tendering for a contract with the health service.</td>
<td>Director’s former partner owns a business tendering for a contract with the health service.</td>
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<tr>
<td>Non-financial</td>
<td></td>
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<tr>
<td><strong>Potential</strong></td>
<td></td>
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</tr>
<tr>
<td>Financial</td>
<td>Director owns shares in a start-up company which intends to provide services in the same sector as the health service.</td>
<td>Director’s friend is a senior employee of the health service, and is likely to be considered for the CEO role (chosen by the board) in the future.</td>
</tr>
<tr>
<td>Non-financial</td>
<td></td>
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<tr>
<td><strong>Perceived</strong></td>
<td></td>
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</tr>
<tr>
<td>Financial</td>
<td>Director was widely known in the community as a partner in a local firm which is a key contractor to the health service, but has divested her stake in the business.</td>
<td>Director’s cousin (who the director has little contact with) is active in a community group that is advocating strongly against proposed changes to the health service.</td>
</tr>
<tr>
<td>Non-financial</td>
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Table 3.1 - Identifying conflicts

Could a decision be doubted due to the perceived, potential or real influences on the decision maker (the director, board or other party)?
Statutory disclosure provisions regarding conflicts of interest and duty

While the Director’s Code of Conduct provides information on conflicts of interest and duty, the Enabling Acts25 (e.g. the HSA) contains disclosure provisions, which require directors:

- disclose any direct or indirect pecuniary interest in a matter being considered by the board
- record the declaration in the minutes of the meeting
- with a conflict must not be present during deliberations and must not vote on the matter.

In practice, this requires directors to be diligent in declaring conflicts. In some cases, a conflict may not be apparent until further discussion or information is devolved. A director must declare a conflict of interest as soon as they become aware.

Where possible, conflicts should be declared and discussion held with the chair (and potentially other directors) to determine how the conflict should be managed going forward.

Identifying a conflict of interest

Directors should proactively review board agenda items prior to any meeting to identify any interest they have relating to those items or that might arise in discussion.

All directors should declare any interest, regardless of whether they think there is a conflict (or not).

The director with the interest cannot be the one to determine whether that interest creates a conflict (or not).

In some instances, this may require that board papers relating to that agenda item are not provided to a director with a known interest or conflict (actual or otherwise). In all circumstances of this nature, the chair should discuss the interest with the relevant director before withholding information to determine if there is a conflict, the materiality of the conflict and if it can be managed.

Directors should also declare any interests at the start of the board meeting and as they arise in discussion, regardless of whether these were on issues on the agenda or whether that director had already disclosed the interest to the chair. The director should not wait for the chair to identify the director’s interest, rather, the director should proactively disclose the interest to the board.

Do I have a conflict?

- Does this further the health service’s goals or mine?
- What assessment would a reasonable person make of this regardless of my belief?
- Could my involvement in this matter cast doubt on my, the board’s or the health service’s integrity?
- If I saw someone else doing this, would I suspect they had a personal interest they were putting before the health service?
- If I did participate in this action or decision, would I be happy if the public became aware of my involvement and any association or connection?
- How would I feel if my actions were covered by the media? Would this embarrass me, the health service, DHHS and/or the Minister?
- Would I have to choose who to be loyal to?

25 See, for e.g., HSA sections. 65W and 134I; ASA section 20; MHA section.364.
In most cases, particularly if the interest is one that the board was not previously aware of, the board should discuss whether the interest creates a conflict or not. This discussion should be led by the chair (or deputy chair if the chair is the party with the interest). The board should have a clear procedure for such discussions, which should include time for the board to consider the conflict of interest without the potentially conflicted director present.

**What about a “positive” conflict of interest?**

A ‘positive conflict’ is where both the conflicted party and the health service benefit from the conflict of interest. On its face, a positive conflict will often appear to be win-win for both parties, however, the question a director must always ask is whether this decision would have been made but for that director’s influence.

Positive conflicts must be avoided, however, directors can provide their services and/or use their contacts for the benefit of the health service provided a *quid pro quo* is not expected (or not perceived to be expected).

**What to do if you have an interest? Disclose!**

Sometimes an interest is unavoidable, even if it presents a conflict of interest.

If a director has identified that they have a conflict of interest and/or duty, they must declare this and discuss it with the board chair and other directors to determine if, and how, it can be managed.

Declarations must be recorded in the minutes of the meeting and the conflicted director must not be present during deliberations and must not vote on the matter.26

A conflict of interest may not necessarily disqualify a person from serving on a board, however full disclosure is a legal and ethical requirement. The matter should be resolved in favour of the health service rather than the individual director.

Obligations in relation to conflicts of interest for health service board directors are also detailed in the PAA as well as the health service’s and DHHS’ relevant conflict of interest policy.27

Obligations with respect to conflicts of interest are also outlined in Victorian Government policy, for

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26 See Appendix 6 for an example of meeting minutes.

example a Declaration of Private Interest (DPI) form must be completed by all applicants when applying for health service board positions and be updated annually for the health service’s records.

The DPI provides the applicant with a formal opportunity to disclose pecuniary interests or other private interests that could reasonably raise an expectation or a real or perceived conflict of interest, or could have a material interference with the proper performance of a director’s duties.

Board applicants with a background in financial management are also required to disclose if they have engaged in consultancy work with professional financial services organisations providing audit, tax and advisory services to Victorian health services. Furthermore, applicants who have provided other high-level advice or management services to any Victorian health services must disclose details of their involvement.

**Absenting from decision making**

Any director can request the disclosing director to absent themselves from the discussion on the conflict, noting that the conflicted director may also need to answer questions from the board before leaving or on return to help the board understand the nature of the conflict. Indeed, the disclosing director can request to be absent. This request should always be complied with (i.e. the disclosing director should leave the discussion) to enable the board to determine:

- if the director is able to participate in the matter for decision and if so, to what extent the director is able to participate in the matter for decision (e.g. full participation, can listen but cannot contribute, can be part of the discussion but cannot vote, etc), OR
- if the director’s participation would cause the decision to be tainted due to that director’s conflict of interest.

**What if the conflict cannot be managed?**

Sometimes a conflict is unavoidable but also cannot be managed by merely absenting oneself from the particular discussion or topic. Examples of this include:

- Where the director has become an employee of the health service or other closely related service provider / contractor
- Where the director has a relationship with an employee or contractor of the health service
- Where the conflict arises far too often to make it practical to continue serving on the board
- Where the director becomes involved in a political party or advocacy group that has a particular interest in what or how this specific health service performs its role
- Where the director has clients or patients that are positions that could influence decision making or quality of care
- Where the director has become involved in some form of dispute (legal or otherwise) with the health service and/or its employees.

This is not an exhaustive list, but demonstrative of the sort of situations where the conflict cannot be merely avoided or managed. In these cases, a leave of absence could be sought (until the conflict is resolved) otherwise resignation will be required.

**Will resignation resolve all conflicts? Not always!**

In general, a conflict that cannot be managed can be resolved by the director resigning. However, there

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are certain circumstances where the director’s resignation will be insufficient to manage the conflict. In these situations, the board and health service will need to continue to manage the conflict despite the resignation.

This is sometimes referred to as ‘ineffective resignation’\(^{29}\), in that the duty will continue to prevent the fiduciary making a profit from the knowledge received due to their position.

**Case study: When resignation is not enough**

Caleb is a director of Better Care Services (BCS) and has been an executive at other health services in the past, enabling him to provide excellent experience about health system operational matters for the board.

BCS is given notice by their current CEO of her intention to resign and the board begins its recruitment process. As part of their strategic planning day, BCS consider the sort of expertise and experience they would like the next CEO to have. Caleb realises his experiences and expertise are a really good fit for what this board needs – it is win, win!

So as to not have a conflict, Caleb resigns from the board and then, after it is publicly advertised, applies for the CEO role.

**Conflict management:**

In this case, the resignation was not enough to resolve the conflict. BCS cannot employ Caleb as the CEO, despite his resignation.

**Why?**

Caleb’s role on the board will have provided him an unfair advantage. This is both in terms of having access to information others would not have, as well as influencing the sort of attributes the board was seeking.

**Confidentiality**

Whilst informal communication between board directors is encouraged, boardroom confidentially must be respected at all times. Discussion of board issues outside of the boardroom such as within the community (i.e. at social gatherings) should not occur, including discussion of the views of other board directors, confidential information, any issues under discussion, and decisions made. It is the responsibility of directors to conduct themselves appropriately to avoid ‘gossip’ and ‘faction building’ with respect to board dynamics.

It is important to note the difference between ‘leaking’ confidential information and the protection offered under the Protected Disclosure Act 2012 (Vic).\(^\text{30}\)

The Protected Disclosure Act 2012 encourages and facilitates the disclosures of improper conduct by public offices, public bodies and other persons, and detrimental action taken in reprisal for a person making a disclosure pursuant to the Act.\(^\text{31}\)

There are no circumstances under which directors can leak information internally or externally.\(^\text{32}\) The VPSC has a quick reference guide\(^\text{33}\) and coordinator to assist directors in making protected disclosures if/where the director believes improper conduct has occurred.

**Informal communications outside board meetings**

Informal communication is one of the most effective ways of sharing information, building knowledge and fostering constructive working relationships. For this reason, boards that communicate regularly with each other and management are typically strong decision-makers.

Board directors must have a united voice when it comes to discussing any relevant and non-confidential matters outside of the boardroom. While the boardroom is a place of robust discussion and challenge, outside the meeting, the board must maintain a unified position, with consistent and clear messages conveyed. Private discussions regarding disagreements or decisions that did not go a certain way only result in a lack of board integrity, dysfunction and potential factions within the board.

**What if a director believes the decision being made is wrong?**

In general, decisions at the board are made by consensus decision making, however there are times when an issue might be polarising enough for some board members that a unanimous consensus or compromise cannot be agreed to. In these cases, the board will vote on the matter and whether it passes will depend on the health services by-laws for such decisions (usually a simple majority is all that is required).

The decision itself is to be noted in the minutes and, if it is of particular importance to the dissenting director(s), then the way those directors voted can be included also (i.e. for or against the proposal). However, it is not usual for the reasons for the dissent to be recorded, particularly if the board minutes are distributed wider than the board. The reason for this is that giving

\(^{30}\) Protection was formally offered under the Whistleblowers Protection Act 2001 (Vic). This Act has now been repealed.

\(^{31}\) See section 4 of the PDA for an explanation of what a protected disclosure is.


‘Board solidarity’ refers to the proper keeping of confidence by board directors, giving the view to outsiders that the board is a united front regardless of any vigorous debate and/or disagreement behind the scenes.

Further air to the dissenting viewpoints will undermine the unity and solidarity of the board and potentially harm the confidence the public has in the board. This is not a case of ‘hiding’ the truth, rather, it is a product of group decision making.

DHHS has prepared a model conduct charter to assist boards with conflict resolution. When putting a Conduct Charter in place, it is recommended the board consider how to pass resolutions where there is disagreement and how to manage the dignity and concerns of the dissenting director(s).

A board director who feels so strongly about a decision that they resign is still prohibited from airing their views about the decision they disagreed with. If the director has a legitimate concern regarding reportable conduct (e.g. fraud, quality and safety, etc.) then the director, as discussed above, ought to report that concern via the appropriate channels (e.g. DHHS or IBAC), not through leaks or gossip.

More information on this is discussed in Chapter 8: Productive meetings.

**Director expenses**

Directors must exercise judgement in relation to reimbursement of expenses associated with fulfilling their responsibilities.

While a director of a board is entitled to be paid reasonable expenses incurred in holding office as a director of the board, there is a level of subjectivity around what is considered reasonable. When considering whether an expense is reasonable, directors must ensure that they adopt an approach that considers:

- was the cost incurred for something that was necessary for me to fulfil my role as director of the entity?
- would the public, DHHS staff member or Minister consider the expense reasonable, such as buying expensive gifts for staff directors or staying in 5-star hotels when travelling to Melbourne for a training course?

Additionally, the VPSC provides guidance for public sector employees regarding gifts and hospitality and the Appointment and Remuneration Guidelines (effective from 1 July 2016) also provide guidance on reimbursement of expenses as well as permitting additional payments to directors for committee work undertaken. These payments are made at the discretion of the Minister.

All expense reimbursements require either board and/or health service approval.

**Travel expenses**

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The Australian Taxation Office’s Taxation Determination (TD 2016/13)\(^{37}\) provides guidance on reasonable amounts for the payment of travel expenses when these are incurred for business purposes. Although this public ruling by the Commissioner of Taxation is not prescriptive, it is recommended that all organisations use these determinations as guidance. Additionally, referring and adhering to the above determination could be beneficial to ensure fair and equitable treatment of staff and strengthen the positive public perception of the health service.

**Reasonable expenses test and examples**

Reimbursable expenses must be:

- for the benefit of the health service

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Conduct, ethics and fiduciary duties

“A fiduciary is someone who has undertaken to act for and on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence.”

- Lord Millett, Mothew (t/a Stapley & Co) v Bristol & West Building Society [1996] EWCA Civ 533.

**Director’s duties**

In addition to their duties under the HSA, PAA and the Director’s Code of Conduct, directors also have a range of statutory and fiduciary duties they must adhere to. A director’s statutory duties are outlined in the next chapter. The most significant of these are the fiduciary duties.

### What is a fiduciary?

A fiduciary is a person who has a clear legal or ethical relationship of trust with another party or parties. Within the fiduciary relationship, one person in a position of vulnerability, justifiably vests confidence, good faith, reliance, and trust in another whose aid, advice or protection is sought. In such a relationship, good conscience requires the fiduciary to act at all times for the sole benefit and interest of the vulnerable person.

### What are a fiduciary’s duties?

Fiduciary duties are prophylactic duties imposed on directors under the equitable doctrines within common law (as opposed to statute or legislation). A fiduciary duty is considered the highest standard of duty and is hinged on the concepts of acting in good faith, for a proper purpose and in the best interests of the entity (to which the duty is owed, in this case, the health service).

The fiduciary status of directors reflects the position of trust and confidence held by directors with respect to the health service. Fiduciary duties are some of the oldest principles in law and are designed to

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39 *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41.

40 Legal principles that have been developed through the court system over time.

41 *Boardman v Phipps* [1967] 2 AC 46.
“...shut out the inducements to perpetrate a wrong, rather than to rely on mere remedial justice after a wrong has been committed...” 42

The duties are generally set out as follows:

- the duty to act in good faith
- the duty to act in the best interests of the health service as a whole
- the duty to not misuse your position or information obtained as a result of your position
- the duty of care and diligence
- the duty to avoid conflicts of interest
- the duty to avoid insolvency
- the duty to retain discretion.

Directors are regarded as having these duties owed to the health service and their importance should not be understated and cannot be compromised.

Various duties are discussed below, as well as how they are applied in practice. It should be noticeable that there is overlap between the duties, with the overall principle being described by Justices’ Gaudron and McHugh in the High Court of Australia,

“In this country, fiduciary obligations arise because a person has come under an obligation to act in another’s interests. As a result, equity imposes on a fiduciary [e.g. the director of a health service] proscriptive obligations – not to obtain any unauthorized benefit from the relationship and not to be in a position of conflict. If these obligations are breached, the fiduciary must account for any profits and make good any losses arising from the breach...” 43

In other words, fiduciary duties are preventive measures to ensure trust reposed in the director (by the health service) is not overcome by the temptation of the director’s self-interest.

**The duty to act in good faith**

It is a duty of loyalty that is owed by each director individually and is assessed subjectively. The duty is directed at the intention, motive and beliefs of the director and whether each made the interests of the health service their principal consideration.

The duty requires directors to exercise their powers only for the purpose which they were granted and permits decisions to be invalidated if their motivating purpose is one which is beyond those which the power can be legitimately exercised.

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43 *Breen v Williams* (1996) 186 CLR 71 [113].
The duty to act in the best interests of the health service as a whole

This requires directors to primarily consult and act in accordance with the interests of the health service itself. Personal or third party interests are secondary to the interests of the health service.

Behaviours that will assist directors with respect to meeting this duty include, but are not limited to:

- acting honestly and on the basis of genuine beliefs
- putting personal interests aside
- demonstrating accountability for their actions
- accepting responsibility for their decisions
- respecting confidentiality
- abstaining from activities that may bring the director or the public entity into disrepute.

Not all breaches of a fiduciary duty are without good faith or dishonesty. Breaches of duty are characterised by the director either placing their own interest before the health service (with or without the director gaining some advantage) or the director compromising the health service’s best interest with the director’s self-interest.

Example: breach of duty without a lack of good faith or dishonesty

Stacey, a director of Better Care Services (BCS), purchased a property knowing that BCS is also going to open a new clinic across the road which would raise the value of Stacey’s future property. She checks the law and notices that she does not need to tell the vendor of the land – it is a real bargain.

As a director, Stacey is prevented by her fiduciary duties from being able to purchase the property because she knows the BCS is about to open a new clinic across the road. If Stacey decides to purchase that property despite her duty not to, she would be forced to disgorge her profits to BCS and there may be other consequences (such as being disqualified as a director by ASIC for breach of fiduciary duty).

What does acting in good faith mean in practice?

Acting in good faith requires that a director has made all reasonable attempts to make decisions that are in the best interest of the organisation. This means that a director:

- must not make decisions based on personal agendas or motivations. When faced with a decision or action for the health service, personal motives such as ‘saving face’ or political, ambitious motivations are not the key drivers for the decision.
- must act on information they know or ought to have known. This is critical for directors to understand because it comes with legal obligations. Directors must be able to demonstrate all reasonable attempts were made to make themselves fully aware of any relevant information upon which they made a decision. This standard has significant implications for the duty of care and diligence also (discussed later in this chapter).
Duty to not misuse position or information

Directors must not improperly use their position or information they receive as a result of their position to gain an advantage for themselves or someone else or cause detriment to the health service. This includes seeking gifts or favours, which casts doubt on the director’s independence.

It is this duty at common law that prevents a person in a superior position (like a director or supervisor) from using their position to coerce another into cooperating or not refusing behaviour they might otherwise refuse. This is normally considered within the context of misusing the position to obtain access to some pecuniary benefit (such as a bribe) or abuse of power. However, it is useful to consider this duty also in light of the conduct a director must demonstrate – abuse of power is not only an issue regarding integrity of decisions, it can also extend to bullying and harassment.

There are many more specific parts of the law that have developed to manage the power imbalance that can occur between a person in a powerful position vis-à-vis another party; for example, a board director and a staff member of the health service. The board is ultimately the employer of the CEO, and thus, the supervisor of every staff member’s employer. While the board does not take part in employment decisions, the power imbalance can be intimidating for a member of staff. As such, the duty to not misuse one’s position extends beyond financial gains. It places a duty on board directors and on the chairperson in particular, to behave in a manner that is fit and proper.

Statutes, OH&S policies and other laws (such as the ‘undue influence’ doctrine in contract law) have

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No actual benefit is required for a breach of fiduciary duty

**Example 1: Patient records - misuse of position**

Jan, a director at BCS, notices her neighbour being admitted via the urgent care centre. She is curious as to if this is related to local pollution or not so she looks at her neighbour’s patient record. The admission is unrelated and Jan does nothing with the information and shares it with no one.

Even without using the information for any benefit, Jan has breached both confidentiality of the patient’s record and has grossly misused her position as director. It will not matter if the director uses the information to his/her advantage – a breach of fiduciary duty does not require a benefit to be conferred.

**Example 2: Mate’s rates – conflict of interest**

BCS puts out a tender for some minor capital works. No local companies apply but two large, outside companies lodge submissions for the tender. After seeing the best offer, Caleb (a director on the board) knows that his brother’s company ‘Local Build Co’ could undercut that rate and still make a profit. After all, Local Build Co built the Caleb’s pergola at a great rate. After confirming with his brother, Caleb offers the board Local Build Co services for “mate’s rates”.

This is a breach of Caleb’s fiduciary duty to the board. While the profit margin for Local Build Co would be much less than it would normally achieve (i.e. the benefit is very small), the abuse of position (and the conflict of interest) prevents the fiduciary (Caleb) from taking part.
arisen to protect employees from such power imbalances, particularly in the workplace. Nevertheless, directors must keep the power imbalance in mind in all interactions with staff.

More information on topics like bullying and harassment are in the next chapter, Statutory Duties. An offence is committed under both statute and common law if it is shown the conduct was undertaken with the intention of gaining an advantage. It is not necessary to establish the advantage was actually obtained – the intention alone is enough to amount to a breach of this duty. Nor does it save the case if a benefit is also conferred on the health service – recall from earlier in this chapter, a positive conflict is still a conflict.

A key principle of fiduciary duties is that no benefit need be demonstrated for a breach to occur.

**Duty of care and diligence**

Directors and other officers must exercise their duties with care and diligence. Whether they have done so or not is an objective test. A director must exercise powers with the degree of care and diligence a reasonable person would:

- as a director or committee member of an entity in that entity’s circumstances
- if they held the same office and had the same responsibilities.

This duty recognises that a higher standard is required of the chair of a health service as compared with a director of a corner shop business, however a high base level of care and diligence is required of all directors.

Matters to consider include the director’s position and responsibilities with the health service, the health service’s circumstances, any special expertise of the director, the director’s ability to ascertain all relevant information, make reasonable enquiries and understand the financial, strategic and other implications of decisions.

Tips to assist with demonstrating care and diligence include:

- understanding and monitoring operations (including systems and controls)
- understanding and questioning proposals put before the board
- participating and making further inquiries as necessary
- understanding and monitoring the financial position of the health service
- reasonable attempts made to understand the situation.

Care and diligence should also be applied with respect to confidential information (as expressed above). Directors are obligated under the Director’s Code of Conduct to ensure that private information remains confidential. This applies to any information - financial, personal, commercial or otherwise - discussed by the board.

Care must be taken to ensure that all confidential information is clearly identified as such and that protocols, including discussions with DHHS and staff, are undertaken with the appropriate levels of professionalism, integrity and confidentiality.

**Do I need to know everything?**

No. This comes back to the idea of reasonableness. A director need not account for risks that are far-fetched and fanciful. Nor does a director need to account for risks that he/she has enquired about and been satisfied with the expert advice (a director is entitled to rely on expert advice). Basically, a director needs to know what is going on and if there is something that a person with that director’s skills would want to know more about, that director must to make reasonable enquiries the answers for which provide the director with assurance.

Reasonable enquires does not mean burdening the executive by extensively probing every single thing.
that crosses the director’s path. For example, there is no need to account for the risk of crocodiles eating your patients (unless that has happened at your service before) because that is not reasonable or foreseeable. It is beyond what a reasonable person would be alerted to.

Nevertheless, the 2011 Federal Court case of ASIC v Healy (the Centro Case\(^{44}\)) highlighted the directors’ responsibilities in relation to a company’s financial statements. The judgement outlined that directors cannot simply rely on specialist advice (e.g. from external auditors) or advice from others (e.g. management) in discharging their duties. The general principles covered by the judgement could be applied to health services regarding endorsement of financial statements.

The main lessons from the Centro case are this:

- All directors must have a minimum level of financial literacy (this could also be extended to a minimum level of literacy in other key governance matters, such as, for health services, clinical governance)
- Directors cannot passively rely on advice from experts – they must, at a minimum, put their mind to it (which includes genuinely reading the material)
- If there are circumstances that might put a reasonable person on alert (in the Centro case it was the instability of the debt markets, for health services it would be quality and safety) then the director must make the effort to be satisfied.

This means, as a director, you cannot simply say ‘we have a great CEO’ or ‘we have great staff’ and walk away. You likely do have both, but you still must put your mind to actively consider the material presented to you. This should not translate to berating or interrogating the CEO, but it will mean a director cannot just sit back and accept what is said, even by experts. A director that says ‘that could never happen to us’ or ‘our CEO takes care of all that’ is likely not fulfilling this key duty of care and diligence.

**Am I better off not knowing anything?**

At law, “knowledge” can be actual or constructive. Actual means, as it sounds, that you actually knew. Constructive knowledge refers to knowledge that can be inferred from other circumstances that you knew OR that a reasonable person, in your position, making reasonable enquiries, would have found out. It is the idea that if you presented the situation to a stranger on the street with similar skills, experience and qualifications as you – would that stranger be put on alert that they should better understand this?

This is where the idea of wilful blindness comes in – have you shut your eyes to the obvious and thus wilfully or recklessly refused to make the sort of enquiries a reasonable person in your position would have made? If so, then you have

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\(^{44}\) Australian Securities and Investments Commission (ASIC) v Healey & Ors [2011] FCA 717.
breached the duty of care and diligence in a manner that is not only a breach, but a dishonest or bad faith breach.

The reason for this development in the law is clear: it is not in the interests of any entity to have a director that can merely close their eyes to any danger or just avoid going to board meetings, in order to avoid liability. Similarly, you cannot just get drunk or skip meetings in order to avoid knowledge. Justice Gibbs in the High Court of Australia described this protective element of the law as:

“...It would not be just that a person who [could recognise] the facts could escape liability because his own moral obtuseness prevented him from recognizing an impropriety that would have been apparent to an ordinary man.”

**Duty to avoid insolvency**

An organisation is considered to be insolvent if it is unable to pay its debts as and when they fall due.

This essentially means, before a new debt is incurred, directors should consider whether it is reasonable to think the organisation may be, or may become, insolvent as a result of incurring the new debt. Directors have a duty to ensure the health service can do this and there is potential for liability for directors if:

- they are on the board at the time the debt is incurred
- the organisation is insolvent or will become insolvent by that debt
- there are reasonable grounds for suspecting the organisation is or will become insolvent, and the director/committee member knew (or should have known) this
- the director/committee member fails to prevent the organisation from incurring the debt.

Pursuant to the Enabling Acts, board directors of health services are not to be held personally liable for anything done or omitted to be done, in good faith when carrying out their duties. Instead, any liability resulting from an act or omission is attached to the health service.

**Code of Ethics – An internal health service guide**

In addition to the Director’s Code of Conduct, health services should put in place their own code of ethics that:

- spells out an organisation’s values and principles
- reflects and shapes the organisation’s culture
- makes transparent the value framework within which the organisation operates.

This internal ethics framework helps provide support and guidance to the health service for ethical decision-making by enabling the important aspects of various situations be highlighted and evaluated. Further, the code of ethics compliments the Director’s Code of Conduct and addresses:

- the practices necessary to maintain confidence in the health service’s integrity
- the practices necessary to take into account the health service’s legal obligations and the reasonable expectations of stakeholders
- the responsibility and accountability of individuals for reporting and investigating reports of unethical practices

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45 Consul Development Pty Ltd v DPC Estates Pty Ltd (1975) 132 CLR 373, [176]-[177].

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• the organisation’s processes with respect to bribes and unethical payments
• the organisation’s processes for handling conflicts.

Whilst not required under the Enabling Acts, the development and implementation of an effective code of ethics aligns with best practice governance and generates real benefits, including:

• increasing the integrity of financial reports and information
• minimising the incidence and encouraging the reporting of fraud and other organisational misconduct
• creating confidence that unethical behaviour will be reported and addressed
• producing a working environment that fosters pride, responsibility and a sense of both purpose and value.

Who can health service directors and/or staff make protected disclosures to?

Protected Disclosure Coordinator
Victorian Public Sector Commission
3 Treasury Place
Melbourne VIC 3002
Telephone: (03) 9651 0835
Email: protected.disclosure@vpsc.vic.gov.au

Independent Broad-based Anti-corruption Commission (IBAC)
GPO Box 24234
Melbourne, VIC 3001
or
Level 1, North Tower
459 Collins Street
Melbourne Vic 3000
Telephone: 1300 735 135
Website: www.ibac.vic.gov.au
Useful references

- Independent Broad-based Anti-corruption Commission (IBAC) website www.ibac.vic.gov.au
- ASIC’s Corporate Governance guidance and resources www.asic.gov.au/regulatory-resources/corporate-governance/
- ASIC’s guidance on conflicts of interest www.asic.gov.au/regulatory-resources/corporate-governance/managing-conflicts/
- Justice Connect’s resources on Governance and legal duties of office holders www.nfplaw.org.au/governance
4. Statutory duties

The board has been given the authority to run the health service. So too is it given legal responsibility for its functioning. All directors should ensure that they individually and collectively comply with all relevant legal obligations. These obligations exist under the respective Enabling Acts, relevant Victorian Government administration acts, subordinate legislation and broader legislation and include topics from employer/employee rights, health & safety, and privacy laws.

Questions that directors of health services should ask

- Do I have a good working knowledge of my Enabling Act and the laws and regulations relevant to the health service?
- How well do I understand my director responsibilities under broader regulations relevant to public sector directors, such as the PAA and FMA?
- Do I know who the key regulators are for Victorian health services and public sector organisations and our responsibilities to them?
- How does the board ensure its directors are compliant with all the relevant obligations?
- Do I understand the regulatory framework in which the health service operates?
- Does the board receive reports from management about material changes to laws and regulations and the impacts this may have on the health service?
- Am I clear as to where the health service stands in terms of its compliance to quality and safety standards? Is the board?
- Have I, and other board directors, received/participated in the appropriate training to enable us to effectively challenge the evidence prevented by management?
- Am I aware of the health service’s by-laws and the legal obligations they contain?

Red flags

- Directors do not fully understand all their legal obligations and responsibilities under the Enabling Acts and other legislation mentioned in this chapter.
- Obligations such as development of the health service’s by-laws, maintaining clinical standards of care and meeting privacy requirements are not known or well understood by directors of the board.
- The board fails to identify or ignores a solvency problem and allows the health service to continue operating or fails to seek further information in relation to the accounts when a reasonable director would do so, thereby breaching the requirements of the FMA.
- The health service has difficulties achieving accreditation and meeting and improving on safety and quality of care performance standards.
- Directors do not fully understand or have not received appropriate information and training on their health and safety obligations and responsibilities.
- Directors passively rely on other director’s expertise and/or do not participate in training.
Introduction to the chapter

Holding a director position on a health service board is a great privilege that comes with significant personal and professional obligations and liabilities. This chapter looks at:

- the Victorian and Commonwealth legislation that supports the provision of health care services within Victoria, including the Enabling Acts
- an overview of other relevant acts that make up this framework

more detailed discussion of work, health and safety legislation and the responsibilities for directors.

Director legal duties and obligations

Directorship comes with a significant amount of professional and legal accountabilities. As discussed in the previous chapter, a director’s fiduciary obligation to ‘act in the best interests on the organisation’ extends beyond the Directors’ Code of Conduct. Critically, this obligation is also enshrined in legislation – for directors of both private and public sector entities.

The VPSC Director’s Code of Conduct, the Enabling Acts and various other acts outline the legal and financial obligations of Victorian public sector entities. In addition, there are broader legal obligations under federal and state laws, such as work health and safety, and privacy laws. Figure 8 below provides a summary of the main relevant acts.

Please note, the above illustration is not exhaustive. Each director should understand and be aware of all applicable duties (both fiduciary and statute).
In the corporate sector, governance and financial management obligations are set out in the Corporations Act 2001 (Cth). This statute can be thought of as the enabling act for companies, including most not-for-profit entities and charities. The Corporations Act 2001 (Cth) does not apply to directors of Victorian health services, however, the principles within this Act are based on the fiduciary duties and concepts discussed in the previous chapter. As such, ideas and training relating to the governance public companies or incorporated associations will broadly apply to health services also.

Enabling Acts

All Victorian public entities, including health services, are established under an act, referred to as its enabling act. Each enabling act outlines how the entity is established, the purpose of the entity and the overarching governance mechanisms to support its operations. It is a requirement for all directors of public sector entities to be familiar with the enabling act relevant to their entity, so as to ensure they fulfil their duties.

The primary piece of enabling legislation for Victorian health services is the HSA. The HSA enables the establishment of legal entities that govern the delivery of health services across the state under various categories or names, namely:

- **public health services** - comprising metropolitan health services and major regional health services
- **public hospitals** - comprising local health services and smaller rural health services
- **multi-purpose services** - comprising integrated health and aged care services provided by several of the smaller rural health services
- **early parenting centres** – a type of public hospital, comprising early intervention and prevention health services
- **other** – including denominational services (which operate like public health services but do not have boards appointed by the Minister) and Health Purchasing Victoria.

AV has metropolitan and regional ambulance services, each with its own board established under the ASA.

Victorian approved mental health services are provided by a range of services located throughout the state established under the MHA.

For governance purposes each of these types of service or agency are treated the same.

Most other public entities in Victoria are incorporated by:

- **Specific statute** (e.g. Assisted Reproductive Treatment Act 2008 established the Victorian Assisted Reproductive Treatment Authority)
- **Associations Incorporation Reform Act 2012** – a state based incorporation mechanism (each state has its own equivalent) regulated by Consumer Affairs Victoria. These entities will usually have the suffix ‘Inc’ at the end of their name to denote they are incorporated.
- **Corporations Act 2001 (Cth)** – for public (including companies limited by guarantee and companies listed on the stock exchange) and private companies, regulated by ASIC and the ACNC. These entities will usually have the suffix ‘Ltd’ (referring to their limited liability) or, if a

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46 Another common enabling statute for incorporated entities is the Associations Incorporation Act, which is a state based statute. An entity can easily transition from an incorporated association to a company.

private company, ‘Pty Ltd’ (referring to being proprietary limited liability).

Other models that businesses use to trade include:

- being a sole trader
- a co-operative (also regulated by Consumer Affairs Victoria)
- a partnership
- an unincorporated association (many small clubs operate this way)
- a corporation registered under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth).

More information about incorporation types is available on the ASIC and the Consumer Affairs websites (refer to references at the end of this chapter).

**Other legal obligations**

The board is responsible for ensuring the health service is compliant with all relevant legislative law. For health services, the board’s responsibilities are primarily derived from the HSA, relevant common law principles and other legislative and regulatory regimes, which include* legislation aimed at:

- **emphasising financial stewardship** e.g. *Financial Management Act 1994* (Vic) and its corresponding Standing Directors of the Minister for Finance, *Audit Act 1994* (Vic), *National Health Reform Act 2011* (Cth)
- **preventing criminal activities within Government entities** e.g. *Independent Broad-based and Anti-corruption Commission Act 2011* (Vic), *Crimes Act 1958* (Vic), *Summary Offences Act 1966* (Vic)
- **specific regulated activities and obligations** e.g. *Public Health and Wellbeing Act 2008* (Vic); *Drugs, Poisons and Controlled Substances Act 1981* (Vic); *Assisted Reproductive Treatment Act 2008* (Vic), *Human Tissue Act 1982* (Vic), *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

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49 Refer to Consumer Affairs Victoria’s website for information about incorporating or not [link](https://www.consumer.vic.gov.au/clubs-and-fundraising/incorporated-associations/become-an-incorporated-association/should-your-club-incorporate)

50 Visit the Australian Health Practitioner Regulation Agency to see the various statutes regarding registered clinicians [link](https://www.ahpra.gov.au/about-ahpra/what-we-do/legislation.aspx)
Additional legislation, standards and regulations also exist with respect to the provision of service for the disabled, children (e.g. child safety), youth, family and aged care, including (but not limited to):

- Child Wellbeing and Safety Act 2005 (Vic),
- Children, Youth and Families Act 2005 (Vic);
- Aged Care Act 1997 (Cth);
- Supported Residential Services (Private Proprietors) Act 2010 (Vic);
- Disability Act 2006 (Vic)
- National Disability Insurance Scheme Act 2013 (Cth)

These are not exhaustive lists, however, key statutes for health service directors are discussed below.

**Where can I find statutes?**


Directors are also subject to a range of legal obligations, including common law and those under various Commonwealth and State/Territory laws such as tax and revenue laws, workers’ compensation laws, consumer protection laws, consumer credit laws, environmental laws and industrial agreements. Directors can be held personally liable under many of these laws and should seek legal advice if unsure of their obligations.

**Key legislation and obligations are briefly detailed below.**

**Financial Management Act 1994 (Vic)**

Applicable to all Victorian public sector entities, the FMA is the governing legislation relating to the accounting and reporting of public money and public property. It is administered by DTF.

The FMA applies to all health services, and requires the CEO, as the accountable person, to appoint a CFO. The FMA requires health services to do a number of things, including:

- keeping proper accounts and records of financial transactions (s 44)
- providing the Minister for Finance with any information requested (s 44A)
- maintaining a register of assets (s 44B)
- preparing an annual report of operations and financial statements (s 45).

**Standing Directions of the Minister for Finance**

In addition to provisions in the FMA, the Minister for Finance issues Standing Directions under the FMA that impose additional requirements on health services. The directions supplement the FMA by prescribing mandatory procedures for financial management controls that must be complied with.
The mandatory procedures are high-level requirements that allow agencies to tailor arrangements to suit their circumstances. DTF has developed the Financial management compliance framework to help public sector agencies comply with the Standing Directions.\(^51\) The Standing Directions cover three areas:

- financial management governance and oversight, including requirements to implement and maintain a financial code of practice and establish an audit committee
- financial management structure, systems, policies and procedures
- financial management reporting, including information to be included in the annual report required under the FMA (s 45).

Instructions and Guidance

Instructions are issued by DTF and are mandatory. The Instructions provide more detailed mandatory requirements, in specific areas of risk and are linked to specific Directions through corresponding numbering.

Guidance is issued by DTF and is non-mandatory. The Guidance provides supporting information in relation to the interpretation and implementation of the Directions and Instructions. The Guidance is linked to specific Directions through corresponding numbering.

While the guidance issued with the standing directions and instructions is not mandatory, it is very useful in determining how to best comply with the FMA, standing directions and instructions. For example, the guidance provides more detail regarding the appropriate composition, skills and qualifications required on the audit committee.

The Audit Committee

Standing Direction 3.2.1 specifically requires that all public entities have an Audit Committee. An exemption can be obtained from this requirement, however, the board then takes on the full accountability of that committee.

Standing Direction 3.2.1 and its accompanying Instructions and Guidance detail the functions, obligations, composition and skills required for the Audit Committee. In addition, the Standing Directions often refer to the Audit Committee as the health service, CEO and CFO (and others, like internal audit) have specific accountabilities to the Audit Committee.

When the internal audit function is co-sourced or outsourced, it is expected that the Committee would provide input to the statement of requirements developed as part of an appointment or tender process. In particular, the Audit Committee needs to ensure the independence of the function is not compromised and consider potential relationships with the external provider that may impair the independence of the assurance process internal audit provides.

For health services, the composition of the Audit Committee must be made up of a majority of independent members (who are generally board directors). An employee of the health service can be a member of the Audit Committee, however, they are not considered an ‘independent’ member. Members of the executive management team (e.g. CEO, CFO) cannot be members of the Audit Committee.

The Chair of the Audit Committee should be one of the directors of the board with the time and capacity to manage the duties and functions of such a critical committee.

The Audit Committee must have appropriate expertise in financial accounting or auditing, which would

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\(^{51}\) This framework, as well as the directions and other related material, is available in the Budget and Financial Management section of the DTF website. Available from: [www.dtf.vic.gov.au](http://www.dtf.vic.gov.au).
include any of the following:

- a thorough knowledge of Australian accounting standards and financial statements;
- experience in applying the Australian accounting standards in connection with financial reporting and public financial statements;
- experience in preparing or auditing general purpose financial statements;
- an understanding of the accounting issues within the specific industry;
- a thorough knowledge of Australian auditing standards; or
- experience with internal controls and procedures for financial reporting.

A health service may look beyond their own board to appoint an external Audit Committee member should no member of their board be able to provide the appropriate expertise in financial accounting or auditing, or to meet the requirement for a majority of independent members.

For further guidance regarding best practice for Audit Committees, refer to the VAGO report on **Audit Committee Governance** (August 2016).\(^{52}\)

Sample Audit Committee charters are available on the VPSC or the Australian National Audit Office\(^ {53}\) websites.

### Audit Act 1994 (Vic)

VAGO conducts financial statement audits of all Victorian public sector health services annually, in accordance with the **Audit Act 1994** (Vic) (Audit Act). VAGO may also conduct performance audits of any health service program area of quality of care or administrative aspect, such as emergency care, safety or waiting list data. The purpose of this is to evaluate whether a health service is achieving its objectives effectively and in compliance with all relevant legislation.

The VPSC recommends that boards maintain a constructive relationship with VAGO, and provide prompt consideration and feedback on any audit opinion or report affecting the health service. An audit often provides opportunities to identify issues within the health service and resolve and improve them.

To ensure compliance with the Audit Act, the VPSC also recommends that the board’s audit and risk committee, and the health service’s internal auditors maintain a constructive relationship with VAGO, and the health service administers a well-targeted program of internal financial and compliance audits preceding VAGO’s audit.

The Standing Directions, Instructions and Guidance also detail audit requirements, including for internal audit, internal controls, reporting and the audit committee.

### Public Administration Act 2004 (Vic)

The **Public Administration Act 2004** (Vic) (PAA) establishes the VPSC and creates the role of the Victorian Public Sector Commissioner. The key compliance obligations of health services under the PAA involve the adherence to public sector service standards and adoption of good governance standards, which the VPSC supports through the development of governance guidance tools.\(^ {54}\) These tools apply to all public sector entities and act as a useful reference regarding the expected standards of conduct, performance and accountability. The Enabling Acts and this Toolkit provide more tailored guidance

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\(^{53}\) Resources and advice available here: [www.anao.gov.au](http://www.anao.gov.au)

\(^{54}\) Various tools are available from: [www.vpsc.vic.gov.au](http://www.vpsc.vic.gov.au)
regarding expectations of governance within the health sector.

The VPSC also administer the People Matter Survey. The People Matter Survey gives public sector employees (including those that work in health services) the opportunity to express their views on how the public sector values and employment principles are demonstrated within their organisations by colleagues, managers and senior leaders.

Survey anonymity is a priority to the VPSC. Responses from individual employees are kept confidential and strict rules are in place to safeguard this at every stage of the survey process. VPSC is committed to responsible privacy practices and is subject to the Privacy and Data Protection Act 2014 and the Health Records Act 2001.

The VPSC also produce the State of the Public Sector in Victoria annual publication. It reports on the employees of the Victorian public sector and their actions to support the Victorian Government and serve the people of the state of Victoria. The report is invaluable when seeking comprehensive information on the composition, workforce and activities of the Victorian public sector.

Independent Broad-based and Anti-corruption Commission Act 2011 (Vic)

The Independent Broad-based and Anti-Corruption Commission Act 2011 (Vic) (IBAC Act) establishes the IBAC, which is responsible for supporting the reporting of public sector corruption, the investigation of reported incidents and the development of preventative measures. IBAC is an independent body with the authority to prosecute acts of corruption within the public sector. IBAC is part of the Victorian integrity system, which means that they are able to share information with Victoria Police and VAGO, to uphold the integrity of the Victorian public sector.

Health service directors have access to the protections of IBAC in identifying and reporting corruption, and are also subject to its powers of investigation and prosecution.

Recent IBAC reports that are relevant to health services include:

- **Operation Tone**: Special report concerning drug use and associated corrupt conduct involving Ambulance Victoria paramedics (September 2017)
- **Operation Liverpool**: An investigation into the conduct of two officers of Bendigo Health, Adam Hardinge and John Mulder (March 2017)
- **Corruption risks associated with the public health sector** (October 2017)

Who can health service directors and/or staff make protected disclosures to?

The VPSC has a quick reference guide for making protected disclosures per the Protected Disclosure Act 2012.

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The sustainability of our health system, the quality of care provided and patient outcomes are dependent on high-functioning teams and a positive workplace culture.

Protected Disclosure Coordinator
Victorian Public Sector Commission (VPSC)
3 Treasury Place
Melbourne VIC 3002
Telephone: (03) 9651 0835
Email: protected disclosure@vpsc.vic.gov.au

Independent Broad-based Anti-corruption Commission (IBAC)
GPO Box 24234
Melbourne, VIC 3001
Telephone: 1300 735 135
Website: www.ibac.vic.gov.au

Fair Work Act 2009 (Cth)
The Fair Work Act 2009 (Cth) contains national workplace relations laws, the National Employment Standards, protection against unfair treatment and discrimination, and grievance handling mechanisms – all of which are also applicable to health services in Victoria. The Fair Work Act 2009 (Cth) allows an employee who reasonably believes they have been bullied at work can apply to the Fair Work Commission for an order to stop the bullying.

The Equal Opportunity Act 2010 (Vic) contains provisions in regards to equal opportunity and protection against discrimination, sexual harassment and victimisation.

Work health and safety governance
Health services are also employers and as a result have a duty of care to ensure any person affected by the health service’s undertakings remains safe at all times and their work activities are not prejudicial to their health.

Having a strong health and safety culture, and an embedded, effective health and safety management system by which management and employees demonstrate accountability, can result in significant benefits for a health service. The failure of organisations to effectively manage health and safety risks has both human and business costs and, as such, should receive the same priority by directors as all other risks.

Health and safety governance is as important as any other aspect of governance and is core to a health service’s overall risk management function, as well as a key responsibility of directors.
Boards are responsible for the occupational health and safety of their employees and consequently, determining the health services’ high-level health and safety strategy and policy, which management are required to implement. This strategy and policy should also include consideration of all persons impacted by the health services’ activities, not just employees (e.g. contractors and visitors). However, board responsibilities should go beyond the issuing of strategy and policy, to also ensure that the implementation of the health and safety policy is effective, by holding management to account through processes of policy and planning, delivery, monitoring and review.

All directors legally required to ensure their health service remains compliant with relevant health and safety legislation. Health service boards are ultimately accountable for providing a safe workplace and Victorian legislation places obligations on the responsible parties to manage these risks, which includes workplace bullying and harassment.

Work health and safety obligations are one of the most significant legal obligations of any director, (public or private) with significant penalties for individual directors and organisations as a whole, should work health and safety requirements not be met.

In Victoria, the key governing legislation is the Occupational Health and Safety Act 2004 (OHSAct), which states an employer must:

- provide and maintain a working environment that is safe and without risks to health, so far as is reasonably practical. This includes identifying and eliminating, controlling or reducing risks to health and safety
- take reasonable care for their own health and safety, and have regard for the health and safety of others.

Presentations and resources on Leading a Safe and Ethical Workplace Culture in Health can be found on the Health Services Governance website, including videos from key speakers on leading indicators (vis lagging indicators) and how to inject positive culture into your workplace.

Director roles and responsibilities

All directors should have a clear understanding of the key health and safety issues for their health service and be continually developing their skills, knowledge and understanding in this area.

All directors should understand their legal responsibilities and their role in governing health and safety matters for their health service. Their roles should be supported by formal individual terms of reference, covering, at a minimum, the oversight of health and safety strategy development, policy setting standards, performance monitoring and oversight of an internal controls framework.

Most commonly, a committee of the board (such as the quality and safety committee or equivalent) should have the role of overseeing and challenging the health and safety governance process.

Complaints regarding director conduct


Statutory duties / 119
Director’s also have obligations regarding their conduct when engaging with fellow directors, management, staff and guests of the health service. Statutes, OH&S policies and other laws (such as the ‘undue influence’ doctrine in contract law) have arisen to protect employees from their supervisor and/or other employees or workplace hazards. Nevertheless, directors must remember that they are in positions of power, so a staff member may not feel equipped or able to speak up.

All boards should have a clear policy and procedures for if a complaint, including:

- A complaint against fellow director within the context of board meetings
- A complaint against fellow director by a director
- A complaint against a director by health service staff
- A complaint against a director by a visitor or consumer of the health service
- A complaint against the chair (by a director, staff member or consumer/visitor)
- A complaint against the CEO (by a director, staff member or consumer/visitor).

Health and safety can be greatly improved through early intervention, appropriate training and education for managers in responding to inappropriate behaviour, and improved management of formal complaints.

Ultimately, the board must drive these behaviours and measures throughout the health service.

Strategic implications

The board is responsible for driving the health and safety agenda. They have oversight and an understanding of the risks and opportunities associated with health and safety, including any market pressures which might compromise the values and standards – ultimately establishing a strategy to respond.

Performance management

The board should ensure they retain oversight of the key objectives and targets for health and safety management, and create an incentive structure for senior executives which drives good health and safety performance, balancing both lead and lag indicators (discussed below), and capturing both tangible and intangible factors. Non-executives (through the remuneration committee) should be involved in establishing the appropriate incentive schemes.

Internal controls

The board should ensure health and safety risks are managed and controlled adequately and that a framework, to ensure compliance with the core standards, is established. It is important governance structures enable management systems, actions and levels of performance to be challenged. This process should utilise, where possible, existing internal control and audit structures and be reviewed by the audit committee, or other suitable committee or board directors, where necessary.

Bullying and harassment

Employee safety and wellbeing is paramount, which includes the risk posed by bullying and harassment in the workplace. Effective board governance and oversight is needed to eradicate this serious workplace issue.

Culture is a topic discussed throughout this Toolkit and it is the board’s duty to set the tone with respect to positive and ‘just’ workplace culture. Part of this duty is ensure the health service has the right strategic direction and policies in place regarding workplace bullying and harassment, which are underpinned by robust systems, processes and people.
What is workplace bullying?

Although there is no agreed national or international definition of bullying, the definition used by the VPSC in its People Matter survey is consistent with that used by WorkSafe Victoria.\(^{61}\) For the purpose of consistency, and in line with the recommendation from the Victorian Taskforce on Violence in Nursing, this is the definition that has been adopted for this online directory.

Workplace bullying is repeated, unreasonable behaviour directed to an employee or a group of employees that creates a risk to health and safety. It should be noted that workplace bullying is not the legitimate and reasonable management of a performance-related matter, a disciplinary process or work allocation issues.

There are a number of other negative behaviours that can occur in workplaces that are not necessarily labelled as bullying but have virtually the same impact on the ‘victim’ and the broader community (in this case, the healthcare setting). Behaviour that is uncivil, unkind, unpleasant, discourteous or nasty can also be damaging to an individual and the people around them. As a consequence, bullying and other negative behaviours that occur within a healthcare setting can significantly impact on patient care.\(^{62}\)

Harassment

Harassment can be against the law when a person is treated less favourably on the basis of certain personal characteristics, such as race, sex, pregnancy, marital status, breastfeeding, age, disability, sexual orientation, gender identity or intersex status.

Sexual harassment is a distinct category of harassment that is prohibited specifically under anti-discrimination laws. Sexual harassment is unwelcome sexual behaviour, which could be expected to make a person feel offended, humiliated or intimidated. Sexual harassment can be physical, verbal or written.\(^{63}\)

There were clear lessons to be learned for all of the health sector from the Expert Advisory Group on discrimination, bullying and sexual harassment Advising the Royal Australasian College of Surgeons (RACS) Report (September 2015).\(^{64}\) RACS has since published an Action Plan, Building Respect, Improving Patient Safety (November 2015) that include goals, training and resources that can be of use to all health services.

Eliminating bullying and harassment in healthcare

In April 2016 DHHS released its strategy Our pathway to change: eliminating bullying and harassment in healthcare.\(^{65}\) Our pathway to change promotes and drives a consistent approach to facilitating culture change, ensuring equity and diversity, addressing bullying and harassment and promoting the safety of

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\(^{64}\) Available here: https://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/reporting/

staff and patients. It recognises the importance of actively driving culture change from a system perspective as well as at the local service level.

The strategy is underpinned by three pillars:

- **Leadership and accountability** - Leaders understand the risk of bullying, harassment and negative workplace cultures, and their responsibility to apply strategies that improve culture and reduce risks will be important to shift organisational responses.

- **Capability building** - Information is critical to ascertain the true prevalence of the problem and target actions and initiatives to address common issues from a system-wide perspective. Building capability to better collect and use information is a key enabler of the change we need. Actions will be taken that advance knowledge and support systems that enable the department, health service leaders and staff to act appropriately and learn and develop.

- **Environment** - Giving consideration to the environment to support initiatives in leadership and capability development is essential for culture change to occur.

As system manager, the department is leading a large program of work to deliver key projects outlined in the strategy. Shifting deeply ingrained cultural and behavioural norms across diverse organisations in the health system will require coordinated and sustained effort.

### Occupational violence

An employer must, so far as is reasonably practicable, provide and maintain a safe and healthy work environment for their employees (employees include independent contractors engaged by an employer and any employees of the independent contractor).

Occupational or work-related violence involves incidents in which a person is abused, threatened or assaulted in circumstances relating to their work. This definition covers a broad range of actions and behaviours that can create a risk to the health and safety of employees.

Examples of work-related violence can include:

- biting, spitting, scratching, hitting, kicking, pushing, shoving, tripping, grabbing
- throwing objects
- verbal threats with or without a weapon
- sexual assault.

### Reducing occupational violence and aggression in Victorian health services

Everyone has the right to feel safe at work. DHHS is taking action to address occupational violence and aggression in Victorian health services. The Government and DHHS are committed to ensuring the safety of staff and patients in our health services and is implementing a number of initiatives to address this complex and multifaceted issue.

*Reducing occupational violence in Victorian hospitals (June 2016)*[^66] outlines DHHS' strategic objectives to prevent and reduce occupational violence and aggression in Victorian health services. It is based on a culture change approach, with strong themes of prevention, early intervention and post-incident response. The strategic objectives and initiatives to achieve them are focussed on raising awareness, building knowledge and capability among the workforce and leadership teams, and embedding systems and processes at the individual, service and system level.

Statutory duties

Preventing and managing occupational violence

The Framework for preventing and managing occupational violence and aggression\(^\text{67}\) (2017) was developed by DHHS to guide health services on how to prevent and respond to the risk of occupational violence.

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violence and aggression from an organisation-wide perspective. The framework covers six domains: governance, prevention, training, response, reporting and investigation.

- Environmental design is a key consideration in addressing occupational violence and aggression in Victorian health services. This might include:
  - Behavioural assessment rooms in emergency departments
  - Installing alarms, CCTV, access control doors, lighting and security systems
  - Consideration of the design of waiting areas, including where staff, patients and guests can move about
  - Trialling new equipment such as body worn cameras.

To help health services identify, assess and control occupational violence hazards and risks in the workplace, the Victorian Government has established the Health Service Violence Prevention Fund. The fund is part of the Victorian Government’s commitment to address occupational violence and aggression in healthcare settings and is being used to remediate risks, with minor capital works targeted at improving the safety of staff in public healthcare services.

DHHS has also developed a *Guide for violence and aggression training in Victorian health services*\(^{68}\) provides training principles based on a tiered approach for different staff groups. These best-practice training principles will support consistency in training across the state.

The guide was developed using literature reviews of standards for developing occupational violence and aggression training in emergency and mental health, as well as consultation with sector representatives in the Violence in Healthcare Reference Group.

Sharing best practice is a key strategy for the health services to better understand what has worked or not in the variety of settings health services experience. Health services can access a range of resources to learn from one another and previous partnerships.\(^{69}\) A number of health services have shared their own training resources on responding to occupational violence and aggression.\(^{70}\)

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**Example: Body-worn cameras**

One of the actions being considered by many health services is the introduction of more extensive audio and visual surveillance to discourage occupational violence and document it when it occurs. Studies have suggested that people moderate their behaviour when they are aware that they are being subject to surveillance. Audio visual footage can also be used as an evidentiary tool to assist with prosecuting perpetrators of occupational violence.

Body-worn camera technology has become increasingly mainstream in recent years. Body-worn cameras have been rolled-out in Victoria and other states in a number of different work contexts including police, parking inspectors, paramedics and security guard.

A policy template for health services is available on the DHHS website (refer to the references at the end of this chapter).

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Resources

To access a range of resources for your health service relating to mitigating occupational violence and aggression, DHHS has a dedicated resource hub that includes information on:

- Resources
- Awareness
- Code Grey and Code Black
- Training
- Sharing best practice
- Post-incident response
- Incident reporting
- Security
- Facility design

Refer to the references at the end of this chapter for more references and resources on OH&S; bullying and harassment; and occupational violence and aggression.

Performance indicators

As part of the health service’s strategic direction, directors should consider and challenge the key performance indicators that the health services’ strategy is linked to. For example, safety performance (particularly numbers of/nature of incidents) is often reported by management, however, if this is done with little to no explanation of the impacts (e.g. on mental and physical wellness), then the board will not be able to fully understand the impact on the business. As such, it is critical to provide both the number/nature of the incident and the impacts.

Lost time injury (LTI) rates have become the cornerstone of mainstream injury/incident reporting and the benchmark against which organisational, industry and national comparisons are made. Although LTI rates are being applied to inform an ever growing range of health and safety problems and decisions, they also have a number of important limitations, such as a poor correlation with both the human and

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financial consequences of work related injury and illness. There are also considerable variations in the
definition of ‘lost time’ across health services, thereby making performance benchmarking comparisons
difficult.

- **‘Lag’ indicators** (e.g. LTI, WorkCover claims) measure outcomes, however, may not provide
  sufficient information for successful management (and treatment of causes) nor provide
  appropriate information for due diligence purposes. For example, lag indicators may provide
  information too late for management to respond effectively.

- **‘Lead’ indicators** (e.g. training sessions held, waning job satisfaction) in contrast to lag indicators,
  provide valuable information that helps the user respond to changing circumstances and take
  actions to achieve desired outcomes or avoid unwanted circumstances. These indicators play an
  important role in motivating continuous improvement, with a focus on areas that have the
  potential to cause an incident, before the incident itself is realised.

What health and safety information should be provided to the board?

Directors should ensure the appropriate level of information is being reported by management to the
board. These reports should be inclusive of lead and lag indicators, and have sufficient information to
support the board’s decision-making. This should be supported by independent and objective assurance
- bringing a systematic, disciplined approach to health and safety risk management, control and
governance processes.

For lead performance indicators to be successful, they need to be selected carefully, for example,
targeting the right/material issues and setting sufficient challenges. Setting a lead performance
indicator and getting a good score does not automatically improve performance. It is not the numbers
that are important, but the quality and application of the gathered information that makes a difference.

A presentation on workplace lead indicators is available on the governance website.  

Integrated approaches to worker health and safety

An Integrated approach brings together worker health and wellbeing, as well as on-the-job safety to
prevent injury and illness and advance health in the workplace.

Evidence tells us that a happy and healthy worker is a more productive worker. We also know that
better alignment of safety, health promotion and human resources programs can create greater
efficiencies for workplaces, by maximising the impact of interventions and reducing duplication of
effort.

There are a range of resources available from DHHS, Worksafe and other health and safety focused
organisations to support health services to improve the health and safety of their workplace.

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Directors’ indemnities and insurance

The Enabling Acts contain provisions that stipulate all board directors of health services are not personally liable for anything done or omitted to be done in good faith when carrying out their duties. Instead, any liability resulting from an act or omission is attached to the health service.

The VMIA provides risk advice and issues insurance services and policies for Victorian Government entities, which includes the corporate liability of health services. The VMIA also provides risk training for health service board directors and executives.

This cover extends to liability arising from negligent medical treatment, which includes individual liability of full and part-time employed doctors and nurses (including private practice work that is specifically covered by the insurance – this will be specific to the particular insurance policy), and contracted visiting medical officers undertaking public work (again, per the policy). Sum insured limits apply and are usually set out in the prescribed schedule of the relevant policy.

The nature and extent of indemnity is dependent upon the circumstances involved and board directors should seek independent legal advice concerning whether to take out additional insurance to cover themselves in all circumstances.

The VPSC provide a summary of liabilities, indemnity and insurance on their website, including implications for former directors and duties that endure after a director has ceased holding office.\(^75\)

Other regulatory bodies

A variety of external bodies provide additional regulatory and oversight roles over specific aspects of the health service’s operations, including HCC, MHCC, AHPRA, the Ombudsman, VAGO, the Coroner’s Court of Victoria, the Aged Care Complaints Investigation Scheme and a number of accreditation systems.

In Victoria, consumers have a right to make complaints about health service providers and to access their health records. The HCC (or MHCC)

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receives, investigates and resolves complaints from users of health services to support health services in providing quality healthcare and to assist them in resolving complaints. If a complaint involves the professional conduct or performance of a registered health practitioner, the commissioner liaises with AHPRA about its handling and resolution.

The role of the Victorian Ombudsman is to investigate administrative actions taken by a Victorian Government or public statutory body, including public health services. These may arise from individual complaints about the administrative actions or through disclosures of serious improper conduct under the Protected Disclosure Act 2012 (Vic). Protected disclosures can also be made to, and handled by, IBAC.

The role of VAGO is largely centred on resource management in the public sector. VAGO’s responsibilities include auditing all public sector organisations, including the department and public service entities. VAGO has complete discretion in deciding whether and how to conduct an audit, and how to prioritise any particular matters.

Coroners investigate unexplained natural deaths, and deaths suspected to be from direct or indirect trauma. Coroners also investigate deaths that occur in health services from time to time, which can lead to a greater understanding of risks and hazards in the community, increased awareness of how the incident could or should have been prevented, and improvements in public health and safety.

Some Victorian public sector health services are approved providers of residential aged care services. Therefore, the role of the Aged Care Complaints Commissioner is to receive complaints or reports of incidents or allegations of physical and sexual assault of residents and unexplained absences of residents from Commonwealth Government-funded aged care services.

DHHS requires all Victorian public health services to be accredited, as it forms a part of achieving the policy objective of continuous improvement of the safety and quality of healthcare. While accreditation against standards alone does not ensure the safety and quality of healthcare provided to consumers, it is effective as part of an improvement system because it can verify actions are being taken, that system data and information are being used to inform the analysis of issues and program solutions, and that safety and quality improvement is being achieved. Similarly, accreditation for residential aged care services is also important as it sets a minimum standard for care and services and promotes continuous improvement.

These other agencies are described further in Chapter 1: Victoria’s Health service governance model and in Appendix 3: Regulatory bodies.

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76 Refer to The Australian Commission on Safety and Quality in Health Care website www.safetyandquality.gov.au
Making protected disclosures

If, as a director a Victorian health service, you are unsure of who to make a disclosure to, contact the Health Services Governance team at board.appointments@dhhs.vic.gov.au for guidance. This can include reporting concerns about behaviours of fellow directors where the conduct does not necessarily reach the thresholds covered by protected disclosures. Where appropriate, a director should first consult their board chair for guidance, as the behaviour of a fellow director may require performance management from the board chair.

The VPSC has a quick reference guide⁷⁷ for making protected disclosures per the PDA. Protected disclosures can be made to:

- Protected Disclosure Coordinator
  Victorian Public Sector Commission (VPSC)
  Telephone: (03) 9651 0835
  Email: protected.disclosure@vpsc.vic.gov.au

- Independent Broad-based Anti-corruption Commission (IBAC)
  Telephone: 1300 735 135

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Useful references

**Governance and legal duties resources**

- The Institute of Internal Auditors Audit Committees: [www.iia.org.au](https://www.iia.org.au)
- *Corporations Act 2001* (Cth) – for an understanding of some of the private director duties.

**OH&S references and resources**

- ‘Anti-bullying’ is a set of resources developed by the Fair Work Commission to provide information on what bullying is at work and what is reasonable action for management to take


- Australasian Health Infrastructure Alliance, Australasian health facility guidelines on environmental design to reduce occupational violence and aggression and increase staff and patient safety (March 2016), AHIA. Available from the AHIA here: https://aushfg-prod-com-au.s3.amazonaws.com/Part%20C%20Whole_5_0.pdf


References and resources relating to other forms of incorporation:

These sites (most of whom are regulators) have a range of resources available that will be broadly applicable to the boards and directors of health services by the nature of their incorporated status.

- Consumer Affairs Victoria (CAV) regulates incorporated associations and co-operatives www.consumer.vic.gov.au

- Australia Securities and Investments Commission (ASIC) regulates all companies, private or public www.asic.gov.au

- The Registrar of Indigenous Corporations has a range of resources available for all incorporated entities and specific training for designed for directors, members and key staff from Aboriginal and Torres Strait Islander corporations www.oric.gov.au

- Australian Charities and Not-for-profits Commission (ACNC) regulates all charities and benevolent entities www.acnc.gov.au

- Not for profit Law (Justice Connect) has guidance material on becoming an incorporated association or a company limited by guarantee. www nfplaw org au/sites/default/files/Incorporated_association_or_company_limited_by_guar antee 1_0.pdf

- business.gov.au is an online government resource for the Australian business community. business.gov.au that offers simple and convenient access to all of the government information, assistance, forms and services www.business.gov.au
Effective boards contain a diverse mix of directors who work cohesively, have a relevant and well balanced skill set and are supported by relevant committees. The structure, selection and composition of boards impacts the performance of individual directors and the collective board, making board appointments and the board evaluation process challenging but critical.

Questions that directors of health services should ask

- Has the board ensured a wide net has been cast for director candidates?
- Is the candidate able to commit sufficient time to discharge board duties? Are they aware of the obligations and expectations?
- Does the board chair regularly review the performance of directors?
- Is a contingency plan established in the event the chair has to step down unexpectedly? Does the board have a formal deputy chair?
- Does the board possess a sufficient range of competencies and experience to effectively deal with the opportunities and issues the health service faces?
- Is there an appropriate mix of skills, backgrounds, experience, age, gender and perspectives on the board?
- Is there an appropriate induction program (including committee induction) for new directors?
- Does the board regularly review its performance, and the effectiveness of its governance processes?
- Does the board have a structured plan, with timeframes and accountabilities, on board succession for its chair and individual directors (particularly regarding key roles like the chairs of committees)?
- Does the board regularly review and identify the skills and resources it needs?
- Is the appointment and reappointment of directors a process that all board directors understand?
- Does the board actively identify future candidates, which will ensure the ongoing sustainability of the health service?
- Does the board and each director understand when the Minister can appoint a delegate or administrator?
- Does the board understand its obligations should a delegate be appointed by the Minister?
- Are there any directors approaching tenure (9 years)? Has the board planned to replace skills that may be lost when these directors reach tenure?
Red flags

- Nominations for chair (where relevant) are undertaken with little consultation.
- The chair does not utilise inclusive leadership (i.e. garner all director opinions).
- The chair also chairs multiple committees.
- No formal (or insufficient) board induction/orientation is provided by the health service to new board directors.
- Boardroom conduct is inappropriate and/or board member relationships are not professional, resulting in inefficient meetings.
- Overuse of external advisers occurs as there are skills gaps on the board.
- The board does not possess a sufficiently diverse range of skills and competencies to facilitate informed and effective decision-making.
- The board does not periodically review its skills and competencies with reference to future strategy and there is a lack of ongoing board succession planning.
- There is limited understanding regarding what constitutes sanctions by the Minister for non-performance.
- Issues of non-performance are a ‘surprise’ to the board.
- Appointment and reappointment recommendations are seen to be lacking transparency with one or more directors dominating the recommendation process.
- There are very few candidates that have been identified, apply or are available for appointment to the board.
- Excessive leaves of absence are occurring leaving the board at risk of being unable to function.
- The CEO is involved in the board recruitment, recommendation and appraisal processes.
- Directors believe they have a right to reappointment.
- A director(s) rarely attends board meetings, committee meetings or public functions hosted by and for the health service.

Introduction to the chapter

Properly structuring the board is one of the most important objectives, which directly determines the success of the health service. The board provides vision and strategic direction, oversight, and votes on all key decisions. It is therefore imperative the board is appropriately structured and each director understands their role as well as the board’s role in the health service.

Board skills, composition and dynamics are critical to the effectiveness of the board. This chapter looks at:

- what to consider when it comes to board structure and composition (e.g. diversity, skills)
- the board recruitment, appraisal and appointment process
- evaluating the effectiveness of the board (including assessment of board skills and behaviours), including ways to address identified gaps.
Board structure and renewal

Governance and board structure
When considering board structure and composition, directors should aim to ensure they are:

- clarifying and communicating the roles and responsibilities of individual directors, the board and its committees
- improving reporting and communication between directors, the board and its committees
- matching the skills and expertise of individual directors with board and committee responsibilities
- providing / seeking appropriate professional development for directors, including training, orientation/induction, mentoring, etc
- ensuring that directors’ competencies and skills are appropriate given the health service’s current and future strategic requirements
- using committees to effectively manage the board’s workload and discharge its duties
- instilling confidence in DHHS and public that the health service is well-governed
- identifying and recommending suitably qualified and skilled candidates who understand their role, responsibilities and obligations of directors in the context of the Victorian public health sector.

The Targeting Zero Report repeatedly described the need for stronger independence for board directors, particularly for rural and regional boards. Recommendations related to independence included introducing board tenure, ensuring boards have an independent clinical (non-executive) director and that all boards have at least one director that is not local.

Board composition
Board composition is an important component of board effectiveness. The board should collectively have a diverse and relevant range of skills, knowledge and personal attributes to effectively deal with the issues and opportunities the health service faces. This requires a collective board understanding and agreement regarding the skills, experience and attributes needed, and an appointment process that addresses key skills gaps.

As well as skills and knowledge it is also important to achieve a balance between new directors and ideas and organisational memory. For complex organisations such as health services it can take time for new directors to develop expertise and add value. As far as possible, appointment terms are staggered to achieve balance between renewal and retention.

Board chairs should continually form a view on the most effective composition for their boards, including skills mix and gaps. Directors should also assist the chair by highlighting skills gaps that may be present on the board or may shortly become present (due to tenure).

It is critical that the board Chair advises DHHS and/or BMAC of any emerging skill or leadership gap to enable proactive management of that risk to the board’s composition.
Board competencies, skills and expertise

Whilst the competencies required for a health service board may vary slightly depending on its strategy, service mix and operating environment (metropolitan, regional, rural), there are a core set of skills and competencies that all health service boards must have:

- clinical expertise and knowledge (medical, nursing, allied health)
- Clinical governance literacy
- financial literacy
- asset management
- information and communications technology
- consumer experience and community knowledge
- Government and health sector knowledge
- legal expertise
- communications and stakeholder engagement
- human resource management
- employment/industrial relations knowledge
- leadership, strategy and vision
- audit and risk management.

This list does not include the general attributes required of every board director, which includes (among other things) core financial, governance and other literacy as well as clinical governance knowledge.

See Chapter 2: Clinical Governance.

Notice that it is not assumed that clinical expertise and knowledge automatically means a director will have clinical governance expertise. Indeed, many professions can bring clinical governance expertise without necessarily clinical experience (and vice versa that clinicians do not always understand clinical governance, particularly at the board level).

Nevertheless, all board directors must have a minimum competency and literacy of clinical governance (not just the clinician) in the same way that all directors (not just the accountant) are required to have a minimum level of financial literacy.

Refer to the Centro case (discussed in Chapter 3) for the requirement of all directors to have minimum financial competency and also awareness of the key matters impacting their entity – in the case of health services the key issue is delivery of high quality, safe, clinical services – which imports an obligation on all directors to understand clinical governance.

Refer, for example, to page 27 of the Targeting Zero report.

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78 Please note, these are the general skills and competencies that each board needs. Not every director will hold each specialist skill set. Although the general skills will likely not change, from year to year the specific definitions and eligibility requirements of each core category may change.
Board diversity

Diversity is an important element in effective and high-performing boards. The economic arguments for greater diversity on boards have been identified in various widely publicised studies. Interestingly, these studies demonstrate a correlation between increased diversity at higher levels of the organisation and stronger organisational and financial performance.

As outlined in the Appointment and Remuneration Guidelines (effective 1 July 2016), appointments to Victorian Government entities should, as far as practicable, reflect the diversity of the Victorian community. Opportunities to appoint women, Indigenous Australians, people with a disability, people from culturally and linguistically diverse backgrounds and lesbian, gay, bisexual, transgender diverse and intersex people should be actively explored.

When planning the recruitment and selection process, DHHS seeks input from the following offices (among others):

- the Office of Aboriginal Affairs Victoria
- the Office of Multicultural Affairs and Citizenship
- the Office of Prevention and Women’s Equality
- the Office of Disability.

In structuring the board to incorporate value from diversity, health services should consider the mix of skills, backgrounds, experience, expertise, age, gender and perspectives of directors that would be necessary to meet the unique requirements of the health service. Diversity is not always about physical, political or social attributes, it can also refer to diversity of thought, diversity of approach and diversity of ideas. The advantages of having a board that comprises different genders, ethnicities, political and social beliefs, are that each individual brings a different view to the decision-making process. An emphasis on director diversity can yield three key benefits:

- an increase in the intellectual resources of the board
- enhancement of the board’s decision-making capabilities, thus lessening the risk of ‘group-think’

Benefits of diversity at board level

A review of multiple studies shows a positive correlation between performance indicators and diversity indices of organisations. By structuring the board to be made up of a diverse range of directors, incorporating such factors as age, gender, culture, background and ethnicity, the performance of the board as a whole is enhanced when compared to less diversified boards.

Benefits of diversity on boards:

- diversity of thought – a greater range of perspectives allows for improved discussion and decision-making.
- increased independence – diversity of board directors can increase the objectivity and accountability of the board.
- enhanced external relations – diversity of board directors allows the board to engage with and represent wider range of stakeholders.
- enhanced internal relations – the representation of a wider range of perspectives can enhance innovation and creativity and improved problem-solving in an organisation.
- improved performance – beyond decision-making, diversity can have positive flow-on effects on both human resource practices as well as financial performance.

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79 See, for e.g. Post C, Byron, K, Women on boards and firm financial performance: A meta-analysis, (October 2014) Academy of Management Journal, 58(S), pp.1546-71. Available from: [http://amj.aom.org/content/58/5/1546.short](http://amj.aom.org/content/58/5/1546.short)

• a stronger connection with consumers, employees and other stakeholders.

It is critical to note that all appointees are directors of the board with all of the duties and obligations that that entails. For example, just as the lawyer on a board is not the legal counsel for the health service, neither is the person with a disability an advocate for people with disabilities. Both are directors. However, just as the lawyer brings particular skills, tools and perspectives to benefit the board, so too will a person of a diverse background.

**Locals or outsiders?**

It is ideal for a board to have a mixture of local and non-local membership for the same reasons as diversity. The reason for the importance of local membership, however, is often misunderstood.

The role of a director from the local community on the board is **not** to represent the community (as community consultation and awareness is a duty for the whole board, including non-local directors). **Boards are governance bodies, not representative bodies** – as such, it would be inappropriate to recruit based only on location. Nevertheless, just as with the diverse perspectives noted above, a local can often have a familiarity with key issues in the community that an outsider may not fully appreciate. Another key advantage for local members is the ability to commit to further roles and functions held by the health service due to reduced travel.

The *Targeting Zero* Report specifically recommended more independent directors particularly for rural and regional boards. The included that independent clinicians and external (i.e. non-locals) directors be appointed to boards to enable a more objective perspective on the board that is independent of local issues and reduce potential ‘group think’. External or non-local directors may also be the only way a board can obtain certain key skills (such as a clinician) – as such, the appointment should, where possible, assist the board in filling a major skills gap while also providing a view independent of local issues or community relationships. This does not reduce the duties or obligations of that external director – including in relation to attendance.

Having non-locals on the board can present its own challenges that the board should consider, including the use of technology to facilitate meetings, the tolerance of the board for this (how many meetings should be attended in person), and how to best accommodate the significant travel burden. For example, if the outsider was the only clinician on the board, the board may want to have the Quality and Safety Committee meeting just before or after (such as the morning after) the board meeting to reduce the burden on that party.

Boards should also consider what supports might be appropriate for new directors to enable them to maximise their contribution. This might include orientation, mentoring, code of conduct, etiquette expectations, consideration of venue and meeting times, visual aids, interpreters or other tools to best support the director settle in and become familiar with the health service.

**Board appointments and tenure**

Directors of health services are appointed to health service boards for up to a period of 3 years. After a director serves their respective term (and they have not reached maximum tenure of 9 years), they become eligible for reappointment and can reapply to the board. However, there is no right to reappointment.

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81 See pages 26-7 of the *Targeting Zero* report.
82 See page 28 of the *Targeting Zero* report.
83 Refer to Recommendation 2.1 of the *Targeting Zero* report.
Public hospital and MPS appointment process considerations

Should a director reach tenure, a process of appointment must take place in order to fill the vacancy and replace those skills. The board (along with DHHS) must publish a notice in a newspaper in the area where the hospital is situated inviting nominations for directorship of the board that advertises and seeks applications from potential candidates. A shortlist is created and candidates are then interviewed by a board panel (consisting of 3 or more directors).

To avoid any conflicts (perceived or otherwise) the board panel should not include the CEO or any board directors with expiring terms. If the board requires assistance in forming a panel (due to Chairperson expiry or availability of board members), the board should seek assistance from DHHS and/or their closest Regional Public Health Service. Candidates are then nominated and recommended (by the board in collaboration with DHHS and BMAC) to the Minister in accordance with the Enabling Acts.

Public health service, VIFMH and AV appointment process considerations

Appointments to the board must be made through nomination by the chair, DHHS and ultimately the Minister. For public hospitals, where a board is already in place, DHHS must publish a notice in a newspaper in the area where the health service is situated inviting nominations for directorship of the board. For all health services, the chair will make recommendations to DHHS with respect to reappointments and other potential candidates. The names of candidates identified by DHHS, in collaboration with the board chair (in order of preference), are then submitted to BMAC and the Minister for consideration. In practice this requires the board, DHHS and BMAC to fully understand the skills lacking and/or required (both technical and behavioural) on the board, in order to meet the Minister’s policy priorities, the obligations of the Enabling Acts and the objectives of the board.

Tenure and appointment considerations

Managing tenure and succession of directors is a particularly important consideration, particularly in regional and rural areas where there is a smaller pool of candidates available to take on board roles.

When making reappointments after periods of long tenure, the following should be considered:

- directors with tenure of 9 years will not be recommended for reappointment
- carefully balance experience and knowledge of the health service associated with long tenure against a fresh new perspective that a new director can bring (often directors with long tenure benefit from a break from director duties, or refresher training to ensure that they are up to date and current with emerging issues and better practice)
- independence is an important attribute of a director, and long tenure can indirectly impact on a director’s ability to remain independent
- familiarity and personal relationships between board directors and management built over long periods of tenure can blur the lines of responsibility and accountability, and therefore new board directors should be considered to ensure greater separation of governance from operations

Ministerial approval of an exemption from the maximum tenure limit is rare and requires substantial rationale and evidence to meet the high requirement. It will also usually require a commitment to manage the issue that the exemption seeks to temporarily address. For example, if the exemption is to manage a skill gap, the health service will then be expected to specifically seek out and recruit a candidate with those skills. Additionally, even if an exception is approved, only a 1 year term will likely be given.

The HLA Bill brings the tenure limitation into law for all health service boards. It also enables the Minister to make exemptions to tenure (rather than the exemption having to be sought from GiC).
Board appointments

Attracting board candidates

In advance of the annual appointment round, health services should be speaking with potential board candidates and alerting them to any upcoming vacancies on the board.

Health services should be proactive in attracting candidates to the board. Health services have historically held information sessions, hospital tours and other local events to attract suitable candidates.

The appointment process

The Enabling Acts (such as the HSA) outline the process for appointment of directors to the respective boards. Refer to Appendix 2 for section references.

Each Enabling Act specifies the minimum and maximum number of directors that each health service must have. A board is not required to have all positions filled, particularly if all skills are covered.

Appointments are made by the GiC on the Minister’s recommendation. Ministerial recommendations are made with the support of the BMAC (discussed further below).

The GiC (on the Minister’s recommendation through Cabinet) has the power to appoint one of the directors to be the board chair.

The Enabling Acts provide for directors to be appointed for terms of up to 3 years, and for them to be reappointed. Board directors cannot hold board positions for longer than 9 consecutive years.

While GiC officially appoints the director, the board should take an active role in the attraction and identification of director candidates for their health service.
Finding people to fill board positions can be difficult, especially in regional and rural areas. A brochure is updated annually and made available to boards to assist public hospital and MPS boards in particular with their recruitment activities.

All boards need to be proactive when it comes to attracting and retaining directors – including giving thought to successional planning.

As vacancies arise, boards should actively engage with the community to help build awareness and interest amongst potential candidates. Activities could include:

- placing advertisements in local and regional papers
- advertising vacancies within the hospital
- updating the health service webpage with useful information for potential candidates
- holding information sessions at the health services for interested candidates to come along and meet the board, understand the role and ask questions
- hold tours of the health service
- engage with professional employers with the necessary skills e.g. the regional health service, the local law firm, etc.

**Position description**

To support activities in attracting new directors, a position description is available to candidates in order for them to self-assess their skills and competencies. An example of a position description is provided in Appendix 5: Director Position Description

**Skills definitions associated with the position description**

Skills definitions are detailed in the position description. These definitions provide guidance on the sort of skills, qualifications and/or experience required in order to satisfy the criteria.

The definitions include a basic minimum standard as well as providing guidance on what a more highly skilled candidate would possess. Further, the definitions indicate the types of responsibilities the candidate might be required to undertake should they be selected as a director of a board.

For example, in order to satisfy the law definition, candidates must show, at the very least, they have obtained a law degree. As stated above, definitions can change from year to year.

**What candidates should expect when applying**

When applying for a director role on a public health board, candidates are required to fill in a number of forms supporting their application. This includes a standard application form that requires the following

**Director due diligence**

The role of the health service director has become increasingly onerous with directors bearing increased responsibility and accountability. It is therefore critical for prospective directors to undertake their own due diligence on the health services they are invited to join. This is to ensure they can make a useful contribution and effectively discharge their duties.

Prior to accepting a board appointment, an individual should:

- investigate the particular health service and the services it provides
- gather information about the people in leadership roles and arrange to speak with key directors and senior management
- review documentation supplied by the health service, such as organisational policies, risks and strategies
- be satisfied that they are equipped with the requisite skills and knowledge to properly discharge their responsibilities as a director.
information:

- contact details
- professional experience - through a resume or curriculum vitae (CV)
- consent to probity checks that will be conducted by DHHS including police checks, insolvency checks and the disqualified director check which will identify any prior breaches of the Corporations Act 2001 (Cth)
- providing DHHS with a DPI to identify any actual, potential or perceived conflicts.

Applications are lodged via the Victorian Government’s online board e-Recruitment tool available at www.getonboard.vic.gov.au

Candidates will also be expected to fill in a police check document should their application be progressed. This will include the requirement for an international police check if the candidate has lived for 12 months or more outside of Australia in the last ten years.

**Boards Ministerial Advisory Committee (BMAC)**

BMAC was established in response to the recommendations from the Targeting Zero report.

Initially, BMAC will consist of four members with each member chosen to represent a specific area of expertise that will facilitate identification of skills gaps on the relevant boards, and allow an effective assessment of the qualifications and experience of potential board appointees.

**BMAC’s key objectives**

The key objectives are to:

- provide advice to the Minister on proposed board appointments to health services
- ensure all boards are highly skilled, independent and objective.

BMAC will also provide advice on proposed board appointments for HPV, AV, and Forensicare to the Minister, the Minister for Ambulance Services, and the Minister for Mental Health, respectively.

**Functions of BMAC**

The proposed functions of BMAC are:

- to provide advice to the Minister on how to ensure all health service boards are highly skilled, independent and effective
- responsibility for overseeing the board appointments process, in accordance with the legislative requirements set out in the Enabling Acts and other relevant Victorian Government policies
- develop clear guidelines covering the skill mix and experience required for health service boards (the skills matrix)
- set expectations for ongoing professional development of board directors
- work closely with health service boards to identify any skill gaps, and advise on how identified skill gaps are best addressed
- work closely with DHHS in determining when delegates should be appointed to health service boards if skills gaps cannot be filled
- consider staggering of board appointments to smooth the appointment process workload.

BMAC will also provide the Minister (and other relevant Ministers) as required, with advice on other matters relating to further improvements to the board appointments process, or matters more generally impacting the effective operation of BMAC.
Board effectiveness and evaluation

Effective boards are the cornerstone of Victoria’s governance model. This includes:

- development of comprehensive induction packages for new board directors
- facilitating ongoing training and education opportunities for board directors
- evaluation of board performance on an annual basis.

DHHS has developed a framework to support board effectiveness, the Building Board Capability Framework. This informs boards of current best practice to achieve board effectiveness and the means by which DHHS will work to support boards to achieve this.


Induction and education

Directors typically bring a wealth of experience to their boards, based on knowledge and skills generated over their careers. Nevertheless, health service boards should develop a comprehensive induction package for new directors, as well as formally assessing, encouraging and financing the ongoing training and education needs of directors and the board as a whole.

While DHHS provides induction training annually for all new health service directors, this should not be relied upon in isolation. Each health service is different with its own challenges and service mix. Induction provided by DHHS is broad to account for all services and does not cover board specific matters such as etiquette, conduct, meeting frequency and other procedural aspects that are matters for the board.

Induction

Board director induction programs should be designed to make the most out of a director’s existing knowledge base by filling any knowledge gaps, typically concerning the health sector landscape and any health service specific issues. Induction programs make it more likely that new directors can make an immediate contribution.

Board director induction programs should be tailored to take into account the appointee’s knowledge and experience, and will vary depending on health service structure, processes and the major issues it faces.

Typically, a combination of written materials, coupled with presentations and activities, such as meetings and site visits, will provide the new director with a realistic picture of the health service’s position and the challenges it faces. It will also serve to foster a constructive relationship between the new director, their fellow directors and senior management.

The chair should take a leading role in ensuring the delivery of a tailored and properly balanced induction program. Initially, a new director should receive an induction pack, which may include the following information:

- **health service information** – strategic plans, the SoP, financial accounts, regulatory frameworks, corporate communications, health sector information, risk profile and appetite, and health service history
- **governance framework** – board charter/governance statement, annual agenda, selected board packs, full details of directors, committee structures, board processes, assurance providers, resources available, key stakeholders, procedures for sign-off of financial statements and items requiring approval outside of board meetings
- **management information** – names and background of senior management, organisational and management structure outline

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• **director’s code of conduct** – roles and responsibilities of both individual board directors and the board as a whole, including behavioural expectations and boardroom conduct for all board directors. This includes codes established by the VPSC (e.g. *Director’s Code of Conduct*) as well as any codes developed specifically by the health service, tailored to its own context and culture.

In addition to the provision of induction materials, it is also important to schedule in-depth meetings for the new directors to discuss the board’s charter, how the health service operates, the main issues facing the health service, the financial position, strategic objectives and other matters of significance.

An induction to board committees, with particular emphasis on those board committees which the new director will join, should not be overlooked. An induction pack containing relevant documents such as committee charters, annual agendas, copies of minutes, plus a full briefing by the relevant committee chair will help the new director gain an appreciation of the major issues.

The VPSC provides a checklist of the sorts of information to be provided to new board directors.84

**Ongoing education**

Through the board evaluation process, areas will be identified where further education may enhance board and individual director effectiveness. The board should ensure resources are budgeted to provide appropriate educational opportunities for directors. The chair should address the developmental needs of the board as a whole, plus those of individual directors. The CEO and management may play a role in facilitating the process.

Training and other resources are available from DHHS, VMIA and other health peak bodies, such as the VMIA, however, it is important that the board manages its own education needs and does not simply passively wait for someone else to provide it.

The development of a Professional Development Calendar can be a useful tool to assist directors in identifying and planning education and training opportunities, which are offered from a range of service providers. An example Professional Development Calendar is provided in Appendix 6.

There are also various online resources that can assist directors, for example, membership of organisations like the Australian Institute of Company Directors.

**Board assessment and evaluation**

Boards should formally evaluate their performance annually to achieve best practice governance with the chair responsible for ensuring it is conducted in a constructive and effective manner. The chair should informally evaluate the board more regularly.

Among other things, the annual performance assessment process should identify skill gaps and training needs, and be used to formulate a program of board education activities for the coming year. In the same way that health services develop staff for their roles, board director development is vital to the effective functioning of the board.

It is essential the board has a formal and rigorous process for regularly reviewing the performance of the board, its committees and individual directors, and addressing any issues that may emerge from that review.

More information on board assessment and evaluation is in *Chapter 8. Productive Meetings.*

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Board evaluation tools

A Skills and Competencies Matrix Capability Assessment (refer to Appendix 6) is a key tool that assists DHHS and health service boards in setting out the mix of capability and diversity that the board currently has or is looking to achieve in its directorship. This is also a useful tool for succession planning and helping identify gaps in the collective skills of the board. This tool should be utilised on an annual basis as part of a broader plan for evaluating the balance of skills, knowledge, experience, independence and diversity on the board. The rationale for this approach is that such an evaluation will enable the identification of specific skills that will best increase board effectiveness.

In addition to a competency assessment, an analysis of director behavioural types may help the board function as an effective decision-making body. When selecting future directors and planning director education, a tailored competency and behavioural-based analysis may assist the board to identify gaps and focus on recruiting individuals with the required competencies.

Board succession planning

Board succession planning challenges boards to anticipate and plan for their future needs. It should be a continuous process that is regularly considered by the board so that changes in the board composition can be anticipated and planned for in advance.

Board succession planning is built on:

- an assessment of the challenges and opportunities facing the health service, now and in the future
- an analysis of the core skills, competencies and behaviours that are required, both immediately and in the future, for both the board and its committees
- an honest evaluation of the skills, competencies and behaviours of existing directors, including their strengths and weaknesses, skills and experience gaps, current age range and gender composition, and length of tenure
- assessments of existing directors’ performance.

In developing a succession plan, the chair’s role needs to be considered. In instances where the current chair’s retirement or tenure date is known, plans should be set to identify a new chair, either internally or externally.

Boards should also have a contingency plan for the chair’s role, and a formal deputy chair, in the case of an unexpected event.

Considerations for board evaluations

1. Independent evaluator

While an independent party is not required every year, it is recommended that the board have an independent performance assessment every 2 (or at the longest) 3 years.

2. Each director should assess and score each other director

This enables performance and behavioural issues to be raised to the board chair’s attention (including the chair’s own performance and conduct). This is particularly helpful for the chair to manage the performance of each director as the assessment is the view of the board, not just the chair or a single complainant.

Consideration should be given to whether each director’s performance is made known to the rest of the board. A useful strategy is to advise the board of the range of scores for that indicator so that the individual director can understand their performance within the context of the range of their immediate peers.

3. Assess attendance (including tardiness)

This measure, while a little absolute, can indicate the level of commitment a board director is either willing or able to commit to the board.

Refer also to: https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/education-resources-for-boards/board-assessment
Succession planning

Continuity of directors is an important factor in boards as it is useful for ongoing knowledge and understanding to be brought to the boardroom. However, it is equally important to have diversity on boards to provide new perspectives, a fresh approach and challenge to possibly well-entrenched board practices. Diversity in age, gender, background, skills and tenure are all equally important.

Recognising there are benefits to having a diverse board means that boards are constantly reviewing the needs of the health service and the ability of individual director’s skills and experience to meet these needs. Succession planning plays an important role in ensuring the required skills are known and that a pool of potential candidates is identified. Succession planning can also involve training of existing board member to ensure that their skills remain relevant to the health service’s current and future needs, so that when a directors’ tenure is reached the board has a range of candidates for the Minister to recommend for appointment.

Astute directors will recognise that it may be time to leave the board, if their skills and experience do not align with the strategic objectives of the health service, and may not seek reappointment in the best interests of the health service. Additionally, directors can fulfil alternative formal and informal roles including acting as a mentor, acting on a different board, ambassadorships, and fundraising and volunteering.

Resignation and removal of directors

Each Enabling Act also provides for the resignation and removal of directors. A director is able to resign by writing a formal letter to GiC. The resignation needs to be formally accepted by GiC in order to be effective. In practice, the letter is addressed to the Minister and submitted to DHHS, which arranges for the letter to be delivered to GiC on behalf of the Minister.

An original letter, signed and dated by the resigning director, is required by GiC to effect the resignation. Only then can the Minister recommend to GiC that the director be released of his/her liabilities and the appointment ceased.

Resigning directors must be aware that their legal duties and responsibilities continue until the effective date of the resignation, which is only when that resignation is formally accepted by GiC.

GiC (on the recommendation of the Minister) has the power to remove a director or all directors of a board. The Minister must recommend the removal of a director if the director:

- is physically or mentally incapacitated
- has been convicted of a serious offence
- has been absent without leave from all board meetings over a six-month period
- becomes an undischarged bankrupt.

Leaves of absence

The Enabling Acts allow the board to authorise leave (e.g. missing one meeting due to illness or a holiday) and acting arrangements as part of their own internal procedures, however, any significant leave of absence (where the person cannot take part in critical decisions, such as where the director is engaged in a legal proceeding or investigation) requires additional steps.

A leave of absence can be requested by a director and must be approved by the board and DHHS. Any leave of absence must be approved and is, as for resignations, not effective until formally accepted by the Government. When approving leaves of absence, the board and DHHS should consider the size of the board and its capacity to meet quorum or effectively make decisions with a board director absent for a period of time.

Where the leave of absence involves a chairperson who was appointed by GiC as the chairperson (such
as the chairperson of a public health service, VIFMH or AV) the board will need to seek consent from the Minister for both the leave of absence and the acting chairperson. This ensures that the Minister responsible for the Enabling Act has authorised the acting chairperson’s authority.

Note a leave of absence cannot exceed six months without special permission. A director can seek special permission from the Minister for a leave of absence greater than six months, but this must be sought well in advance as the leave may require the approval of GiC.

**Board committees**

Board committees provide an additional way for a board to effectively structure their workloads through the delegation of more comprehensive examination of key strategic or risk issues. Committees carry out a thorough analysis of important matters and make recommendations for the board to consider.

**The board remains accountable for all decisions.**

Under the HSA (as an example), boards are required to establish three committees: finance, audit and quality committees. This requirement was expanded to public hospitals and MPS under the HLA Bill.

The Standing Directions of the FMA\(^\text{86}\) also requires all health services establish an audit committee to oversee and advise the board and CEO on matters of accountability and internal control affecting the operations of the health service. The primary role of an audit committee is to consider reports from officers of the entity and the auditors that provide assurance about the integrity of the entity's financial processes, systems and reporting.

Please note that the board chair should not be the chair of the audit committee. For more information on audit committee structure and requirements, refer to Chapter 4: Statutory Duties.

The Government’s executive remuneration policy also requires all boards to establish a remuneration committee with at least three directors. The role of a remuneration committee is to determine the health service’s policy and practice for executive remuneration, and the individual remuneration packages for its executives.

It is common practice for large health services to have additional committees such as an education and research committee. Committees may be standing committees or established for a specific purpose. Carver (1997, pp. 145–147) and many other governance experts favour a minimalist approach to committees, counselling they should be established to aid the process of governance, not management.

The VPSC advises that committees should be established with:

- a specific charter, with clear terms of reference
- delegations that do not undermine the board’s delegations to the CEO
- an appropriate number of directors
- procedures for agendas, minutes and reporting to the board
- a clear expectation that the decision-making responsibilities of the board are not to be compromised by the activities of any committee, and that significant issues will be reported to the board for discussion and decision-making.\(^\text{87}\)

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Advisory committees

The HSA requires the boards of directors of metropolitan and major regional health services to appoint a primary care and population health advisory committee, and a community advisory committee. It also specifies that boards may appoint other advisory committees if they choose.

With respect to community advisory committees, boards:

- are able to decide the number of directors
- must ensure the directors are people able to represent the views of the communities served by the health service
- must give preference to people who are not registered health practitioners within the meaning of the Health Practitioner Regulation National Law Act 2009 (Vic) and who are not currently, or recently, involved in providing health services
- must fill a vacancy within three months of it arising.

With respect to primary care and population health advisory committees, boards:

- are able to decide the number of directors
- must ensure the directors have between them:
  - expertise in, or knowledge of, the provision of primary health services in the areas served by the health service
  - expertise in identifying health issues affecting the population serviced by the health service and designing strategies to improve the health of that population
  - knowledge of the healthcare services provided by local Government in the areas served by the health service
- must fill a vacancy within three months of it arising.

The HSA permits the Secretary to publish guidelines relating to the composition, role, functions and procedure of advisory committees. Subject to any guidelines, the HSA states the procedure of an advisory committee is in its discretion. Guidelines have been established for community advisory committees but not for primary care and population health advisory committees.

The guidelines define the role of the community advisory committee as follows:

- to provide direction and leadership in relation to the integration of consumer, carer and community views into all levels of health service operations, planning and policy development
- to advocate to the board on behalf of the community, consumers and carers.

Managing non-performance

The Enabling Acts set out the role of the board. Boards are responsible to the Minister for the effective and efficient governance of their health service, including the requirements, mechanisms and processes surrounding board appointments, function and objectives.

The HSA sets out several options available to the Minister for managing non-performance should some or the entire board be unable to adequately fulfil its obligations under the HSA. This includes, but is not limited to:

- removal and resignation of directors (the board can also seek approval for the removal of a director or directors)
- appointment of one or more delegates
- appointment of an administrator
- other sanctions (e.g. censure, instructions that a health service is required to follow).
Performance management of individual directors (regarding performance or behaviours) is primarily a matter for the board chair. This is discussed in more detail in Chapter 11: Organisational culture and leadership.

Removal of directors

The GiC, on recommendation of the Minister, may remove a director from a health service board. Common reasons for director removal relate to non-performance and failure to meet their obligations under the relevant Enabling Act, failure to act in accordance with the law and inappropriate behaviours. The Minister must provide written notice to the director (and the board).

For ‘public health services’, s65V of the HSA outlines more specific criteria wherein the Minister must recommend the removal of a director if they:

- are physically or mentally unable to fulfil the role of a director of a board
- have been convicted or found guilty of an offence, the commission of which, in the opinion of the Minister, makes the director unsuitable to be a director of a board
- have been absent, without leave of the board, from all meetings of the board held during a 6-9 month period.

Specific details of the relevant sections of the Enabling Acts relating to removal of directors is outlined in Appendix 2.

Appointment of a delegate

The Enabling Acts permit the Minister to appoint up to two delegates to a board to attend meetings and provide advice and information to assist the board in their understanding of their obligations under the HSA if they believe a delegate appointment will assist with improving the health service’s performance.

The relevant sections of the Enabling Acts relating to appointment of board delegates are outlined in Appendix 2.

The role of the delegate is to observe how the board operates and provide guidance and advice to the board, with the intention of providing feedback to the Minister regarding the board’s abilities to fulfil its duties under the Enabling Act. Specifically, the delegate is required to:

- attend meetings of the board and observe its decision-making processes
- provide advice or information to the board to assist it in understanding its obligations under the relevant Enabling Act
- advise the Minister and the Secretary on any matter relating to the health service or the board.

It is therefore important the delegate is skilled in governance and the requirements of the Enabling Acts, such that recommendations or improvements can be made to assist the board to improve the performance of the health service.

The HLA Bill expands the circumstances for which the Minister can appoint a delegate, including where it might assist in the establishment of a new health service (i.e. to assist a new board) and to improve quality and safety of the health service.

The Minister can appoint up to two delegates to the board for a period of up to 12 months, irrespective of whether the board has requested it. The appointment of a delegate must be published in the Government Gazette, with details of the term of appointment and any remuneration. Delegates must
not be a board director of a health service and can apply for reappointment when they reach the end of their term. The Minister may also revoke the appointment of a delegate.

**Obligations of the board to the delegate**

The board must allow a delegate to attend any meeting of the board and provide them with all relevant information or notices provided to other directors during their appointment. In other words, delegates are to be treated as an ordinary board director for all board processes. The delegate may be required to vote and the board must allow them to participate in the voting process.

**Appointment of administrator**

The GiC, on the recommendation of the Minister, may appoint an administrator to exercise all the powers of the board. The administrator is subject to all the duties of the board. On the appointment of an administrator, the directors of the board cease to hold office. The appointment of the administrator can be revoked, with 28 days public notice. Revocation will be followed by election and appointment of a new board in accordance with the relevant requirements.

The Enabling Acts permit the Minister to recommend the appointment of an administrator, and/or that the health service be closed, if the Minister is satisfied that (not exhaustive):

- the service is inefficient or incompetently managed
- the service is failing to carry out its functions, or failing to carry them out effectively
- the service has negligently failed to comply with an agreement entered into under the relevant Enabling Act

The HSA Bill expands the grounds for the Minister to appoint an administrator to include circumstances where the health service has:

- has failed to provide safe, patient-centred and appropriate health services; or
- has failed to foster continuous improvement in the quality and safety of the care and health services it provides.

The GiC must endorse this process.

In the event the Minister proposes the appointment of an administrator, the Minister must give written notice to the health service and consider any submissions made by the service within seven days of the notice. All directors of the board cease to hold office upon the appointment of an administrator.

The relevant sections of the Enabling Acts relating to appointment of an administrator are outlined in Appendix 2.

**Amalgamation**

The GiC, on recommendation of the Minister after receiving advice from the Secretary, may direct two or more registered health services to amalgamate. Any direction to amalgamate must be made by Order and published in the Government Gazette. In this instance, the two entities directed to amalgamate will cease to exist and be wound up. A new entity and a new board will then be established under the relevant Enabling Act.

An amalgamation may be ordered if the Secretary is satisfied that the health services can be more effectively delivered under a new structure. Before the recommendation can be made to the Minister and GiC, a report must be prepared that outlines the rationale and proposed structure to take the health services forward. For example, s64 of the HSA outlines the process and administrative requirements that must be adopted before an amalgamation can take place. Given the extent of consultation that must occur before this decision can be made, this option is one that requires strong rationale, but one that ultimately supports the effective achievement of the objectives of the Enabling
Significantly, no Victorian health service has been forced to amalgamate. All amalgamations of health services have been voluntary and reflect both the other powers available to the Minister (such as an administrator or delegate appointment) and what is best for those two (or more) agencies determined by those agencies. The HSA Bill also amends the HSA to enable MPS to engage in voluntary amalgamations.

The relevant sections of the Enabling Acts relating to board amalgamations are outlined in Appendix 2.
Useful references


Papers/4_Board-Assessment.pdf [Note: site registration at www.nadler-leadership-advisory.com may be required to access white papers].

- HSA Bill 2nd reading speech can be accessed from Hansard at legislation.vic.gov.au
- Clinical Governance Framework at Chapter 2.
6. Insightful strategy

One of the main responsibilities of the board is to see further than anyone else. They must have a vision for the health service that is forward thinking. It is imperative for the board to review, assess and determine the health, economic, technological and demographic trends that are, and will, shape Victoria, Australia and the world.

Developing effective and insightful strategy is critical in order to manage risk and take advantage of emerging strategic opportunities. Boards must ensure the health service is agile and can respond to changes such as Commonwealth and Victorian Government policy and funding.

Questions that directors of health services should ask

- Does the board consider future strategy when making decisions? Are alternative strategies also considered?
- Does the board have a clear view and understanding of the length and impact of the strategy that supports the decision (e.g. at the 6 month and 10 year marks)?
- Does the board have a well-defined process in place to monitor the quality of management’s execution in terms of agreed strategic objectives and performance measures?
- Do I, and the board, challenge management to ensure better implementation of the board’s strategy? How do we measure and monitor success?
- Are the strategic options presented by management based on robust and thorough analysis using established tools and methodologies?
- Are post-implementation reviews completed for all major projects?
- Are there annual strategic planning day(s) with board attendance to discuss and approve the strategic objectives?
- Do I, and the board, drive management to develop an operating model that provides the health service with the ability to effectively assist the Minister in fulfilling their policy goals and the requirements of the Enabling Acts?
- What is our purpose? What are we here for?

Red flags

- Board meetings are not strategically focused.
- There is no long term thinking or approach to health service provision.
- The board does not understand the strategic direction and/or accepts the executive’s implementation strategy without question.
- The board does not fully understand the nature and implications of the proposed strategy.
- The external environment is not fully considered in strategy development.
- Not all directors attend the meeting where strategy is discussed and approved.
- Risks inherent in the strategy are not defined or managed.
Mechanisms for measuring stakeholder value are not fully understood.

Too much emphasis is placed on operational and/or financial performance measures.

Introduction to the chapter

One of the main functions of the board is to create the health service’s vision and strategic objectives. The board must also monitor progress against these objectives once they have been set. Doing this effectively, requires clear systems, tools and information/data to ensure the current and future healthcare needs of the health service’s community are met as part of the broader health system.

This chapter will look at:

- the board’s role in strategy
- the processes and tools to assist in the creation, implementation and monitoring of the strategy, which includes:
  - strategic planning and development
  - key products and considerations
  - communication and ensuring implementation
  - monitoring and evaluating.

Insightful strategy

Good governance is about performance as well as compliance.

The performance dimension of a board’s role focuses on the health service’s strategy and the pursuit of stakeholder value, with the aim of providing safe, high quality care for the community, as measured by the Minister and DHHS.

The board’s role in strategy is essential. Cooperative and interactive strategic planning processes must be instituted, which enable boards and management to:

- make, review and assess strategic decisions
- understand the key drivers of health service performance against the agreed strategic priorities
- align the health service’s strategy, operations and external environment
- understand potential risks and incorporate risk management into strategic decision-making.

The board’s role in strategic planning and development

Boards are responsible for ensuring the organisation is agile enough to continue providing safe, high quality health care in an environment of changing health service needs, Government policy and funding mechanisms, and to be able to take advantage of emerging opportunities. The strategic focus of the board is essential in order to provide leadership to the organisation.

With regard to strategy, it is the responsibility of the board to plan, enact and monitor as detailed in Figure 10 below.
Strategic development challenges

Directors may often struggle to make a meaningful impact on the strategy process. This can occur for a number of reasons, including:

- limited knowledge of the health service’s clinical and operating context
- failure to be fully aware of, and understand, the short and long term health sector trends
- time constraints
- board time being taken up with compliance and/or operational issues
- executives being unwilling to incorporate director input
- the board failing to hold a forum which facilitates director participation (such as a specific strategic planning workshop for the board)
- accepting a ‘final’ strategy rather than discussing options.

As a result, some boards may find they are sidelined in the strategy development process, being confined to merely approving or rejecting proposals. Reviewing, adding value to, and approving the strategy are crucial to the board’s governance role. Boards need to be seen by management as a strategic resource that contributes to superior health service performance. Through the board’s unique position, directors can contribute by providing:

- policy context and health sector trends
- experience and expertise accumulated during their professional careers or roles in the community
- new perspectives, challenging thinking and fresh ideas
- an independent and objective viewpoint.

These strengths, combined with management’s in-depth knowledge and experience in health service operations, mean that collaborative decision-making often leads to better strategy. Directors are more likely to add value to the strategy process if they possess a strong understanding of the health service and its environment, have strong meaningful working relationships with each other, as well as the
management team, and are able to communicate and exchange information effectively.

**Key products**

Being a health service and a public entity, the key elements of the board’s strategy will be met through the development of two key products that are required by DHHS. This includes:

- preparation of the health service’s strategic plan
- agreeing the SoP (or other relevant health service agreement) with the Minister or Secretary.

**Strategic Plan**

The Enabling Acts require that health services prepare a strategic plan for approval by the Minister (except for public hospitals and MPS where the Secretary may approve the strategic plan). The strategic plan must outline:

- the health service’s role and objectives
- strategies to ensure the effective and efficient provision of health services and the financial viability of the health service.
- The strategic plan provides the three to five year high level objectives of the health service and sets the overall context for the accountabilities outlined in the SoP.

**Statement of Priorities**

The SoP is the key accountability agreement for health services and is agreed each year between the Minister and the health service board. Some types of health service will sign a SoP with the Secretary or Secretary’s delegate.

A health service’s SoP must:

- be consistent with the health service’s approved strategic plan
- set out the services to be provided by the health service and the funds provided to achieve this
- set out the objectives, priorities and key performance outcomes to be met by the health service
- set out the performance indicators, targets or other measures against which the health service’s performance is to be assessed and monitored
- set out how and when the health service reports to the Minister and the Secretary on its performance in relation to the specified objectives, priorities and key performance outcomes
- set out any other matters agreed by the Minister and board, or determined by the Minister.

The SoP is developed collaboratively by the health service and DHHS on behalf of the board and the Minister or Secretary, and is approved and signed by the board chair and the Minister or Secretary/Secretary’s delegate as applicable. In the event that a SoP is not agreed by 1 October each

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88 Note that the HSA Bill will enable the Secretary, DHHS to require a strategic plan from public hospitals and MPS services.

89 It is recommended you align your SoP (or health service agreement) with DHHS’ strategic plan, which is available online. The DHHS’ 2017 Strategic Plan can be found at: [https://dhhs.vic.gov.au/strategic-plan-department-health-and-human-services](https://dhhs.vic.gov.au/strategic-plan-department-health-and-human-services)

90 Not all health services have SoPs. A health service may instead sign a health service or tripartite agreement.
year, the HSA, for example, allows the Minister to determine a SoP for the health service. More information about the SoP is in Chapter 12: Accountability and Performance.

Key considerations when developing strategy

Strategy development requires directors to be curious, well-informed and ask questions. It directly relates to the board’s ability to identify and interpret the impact of issues occurring in and around the health sector that can shape the short term and long term needs of the organisation.

Sustainability and viability

Directors are tasked with one of the fundamental aims of health service strategy which is to ensure the ongoing viability and sustainability of the health service.

Creating a viable and sustainable health service over the long-term necessitates that organisations are as flexible and responsive as they can be.

Directors should focus on developing a strategy which is based on robust stakeholder engagement, analysis of funding scenarios, consumer needs and policy directives. Each of these can assist health service boards with the following:

- identifying and implementing the best operating model for the respective health service
- innovation in delivery of health services with respect to governance and clinical care
- effective use of assets and resources
- provision of health services relevant to their community’s current and emerging needs
- the collective skills and experience of the executive and management team
- well integrated service delivery with other health and community service providers.

Strategic thinking

Strategic thinking refers to the ability to think laterally and creatively towards developing a clear and focused business vision. It requires directors to be flexible in their ideas and how to approach them.

The best strategic thinkers are those who are curious and committed to learning rather than believing that they have all the answers before they start.

Strategic risk

Boards must identify, assess and manage the risks inherent in any strategic plan. Strategic plans often do not achieve their desired aims, are poorly executed, or fail to keep pace with changes to the health service’s environment.

Directors should seek to satisfy themselves that an effective strategic risk management plan is in place and is being followed. Such plans seek to:

- identify and evaluate strategic risks
- consider emerging risks and trends
- measure what is happening

Further detail relating to SoPs can be found in the Enabling Acts (e.g. HSA), PMF and PFG and available from: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/statement-of-priorities
• prepare for, and take appropriate corrective action.

Boards must try to balance both short and longer-term strategic risk. Strategic risk increases as the time horizon expands – the longer the timeframe, the more unpredictable it becomes, and thus the more sophisticated the organisation’s risk management capabilities need to be. Many health services develop scenarios that deal with a variety of alternatives to mitigate this problem. Risk management is an increasingly vital part of organisational accountability and strategic decision-making.

Identifying strategic risks can be challenging. There is a broad range of risks that can impact on the ability of a health service to meet its objectives. Directors must be appropriately skilled, and devote a suitable amount of time, to understanding the broader context within which safe and quality care is delivered.

Risks will be constantly evolving and emerging. In developing strategy, directors need know the internal and external environment well enough to be able to determine what the key risks to the organisation meeting its objectives are. This takes a dedication to continually and proactively seek information, share knowledge and ask ‘what does this mean for our health service?’

For more information regarding risk management, please refer to Chapter 7 – Risk management.

Future proofing

A good strategy presents a vision for the future and a roadmap for how the health service will get there. An effective, well-articulated, strategic plan is critical for organisational success. Developing a strategy that presents a clear picture, aligned with Government policy and Ministerial directions, of where the health service is heading. Boards should develop a culture of forward thinking. This can be assisted by:

• creating a climate where strategic thinking is a valued activity
• fostering a culture of questioning, learning and constructive challenge of the way things are traditionally done
• challenging and evaluating the processes for developing strategy, not just the strategies themselves
• upholding high expectations for strategic plans
• setting aside adequate time and resources to discuss strategy in a meaningful way
• establishing methodologies, tools and policies for strategic decision-making and monitoring management adherence to them
• considering the needs of the health service’s stakeholders
• putting aside your own agenda and focusing on what is best for the health service within the context of the broader Victorian health system.

Communicating and ensuring implementation

Stakeholder involvement in strategic planning

A critical step in the strategic planning process is engaging with key stakeholders. In its broadest sense, a health service’s stakeholders are those groups who affect and/or are affected by the organisation and its activities.

The Minister and DHHS are considered primary stakeholders, however directors should also consider consumers, other health services, emergency service providers, members of the external regulatory framework (such as the Ombudsman), employees and the broader community when communicating strategy.

Boards face ongoing scrutiny and increasingly high expectations from stakeholders. As part of their responsibility for governance oversight, directors need to identify and understand the expectations of
There is a danger that health services become complacent in their strategy, making incremental adjustments whilst the policy and clinical environments continue to change rapidly.

More agile health services influence their environment and will quickly overtake those that merely react to it.

For more information regarding stakeholder engagement, please refer to Chapter 9 – Stakeholder engagement.

**Strategy review**

Strategies should never be ‘set and forget’. Rather than developing a strategy and then putting it on the shelf until next time, a strategy needs to be continually reviewed and its implementation monitored.

It is the board’s responsibility to conduct a thorough analysis of the current strategy and progress towards the agreed objectives, and to evaluate health service performance in light of these objectives. A board will normally review strategic direction at least annually. Strategies should also be subject to reviews to ensure they remain appropriate and relevant to the organisation’s (and stakeholders’) needs.

As part of this role, boards must ensure management effectively implement the strategy the board sets. Boards must be vigilant in assessing the performance of the health service in line with the strategic objectives. Periodic reporting from management (such as a quarterly report card incorporating exception reporting) can help the board quickly come to terms with what is not working and why.

It is important the board receives the appropriate facts and information to make an accurate assessment. Financial and operational reports are a good starting point, but given the key objective of health services is to provide safe, quality care, the board also requires non-financial performance indicators. These may include indicators of consumer satisfaction, employee engagement, quality of care reviews, patient flows (including how they relate to other health services), community feedback and engagement. The board is there to look objectively at strategy and make the tough decision to mitigate a risk, take advantage of an opportunity and/or change the course of the health service when it is no longer viable.

Rather than trying to predict the future, the board can ensure the organisation’s capabilities and resources are sufficient to manage uncertainty and that strategic plans are flexible. In-built flexibility is promoted by:

- scanning the environment constantly and keeping abreast of changes that could materially affect the achievement of strategic objectives
- exploring how policy shifts and clinical developments (or risks) will impact on strategy
- inviting subject matter experts to address the board and senior management

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ensuring accurate and timely information reaches the board and is discussed candidly by directors and managers by scheduling ‘break-out’ sessions to allow the board to critique the current strategy.

Monitoring and evaluation

As part of the planning process, directors should have clearly defined the objectives and outcomes of the plan that they wish to see implemented. It is essential to determine what successful outcomes will look like and what evidence will be needed to demonstrate success.

Directors should ensure there is a system by which they can check whether their strategy is working to achieve the intended impact.

Monitoring and evaluation is about learning from what you are doing and how you are doing it, and taking action to adjust the strategy accordingly. Regular monitoring and evaluation will help directors to assess how well the health service is tracking against the objectives set by the board, and ensure the health service is allocating time and resources effectively.

It is important to remember boards must respond through governance, not through delving into operations. When monitoring the health service’s strategy, boards do not need to come up with all the answers. Good governance is:

- assigning responsibility to those who do
- understanding the types of responses available (process, systems, legal responsibilities)
- developing appropriate accountabilities (KPIs, patient stories, case reviews).

Measuring performance and assessing your strategy

Demonstrating performance to stakeholders – the PMF

Health services are obligated to regularly track and report their performance to DHHS as part of the PMF. The PMF requires health services to adopt processes aimed at continual performance improvement across a range of domains and objectives. Performance is tracked closely to ensure strategic objectives and KPIs set out in the SoP are being met, and that remedial actions can be implemented if necessary.

Boards should ensure internal reporting aligns closely to the SoP and Strategic Plan to avoid duplication of effort when reporting to DHHS. A range of tools are available for directors and boards to assist with meeting the requirements of the PMF.

Please see Chapter 12 - Accountability and performance for a more detailed guide.92

The balanced scorecard method

The balanced scorecard method is used by many organisations as a better practice approach to setting performance measures and subsequently measuring actual performance. The PMF utilises a balanced scorecard approach.

To increase performance (financial, operational and clinical), health services must do things such as engage in activities, processes, programs and projects. Directors must go beyond the financials to discover value drivers and the different levers available to the organisation to affect positive clinical and

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financial outcomes. For example, a focus on reducing costs by cutting back staff numbers, may have a positive effect on the bottom line, but is likely to have a negative impact on clinical practices – with fewer staff available to perform tasks in a timely manner.

Directors must learn to measure the value drivers if they are to guide the executive team on how to manage them.

The balanced scorecard approach recommends boards view their health service from many perspectives:

- **Clinical** – How safe is our health service and how do we know? What are the key indicators for our health service to monitor to satisfy ourselves that we are providing high-quality health care?
- **Financial** – How does our performance look to stakeholders? Are we adding value? How do financial drivers relate to clinical outcomes?
- **Consumer** – How do consumers see us? What sort of feedback are we getting from them directly or from other sources (e.g. DHHS, HCC)?
- **Internal business perspective** – What must we excel at? How can we operate more efficiently (including better use of funding models)?
- **Innovation and learning** – Can we continue to innovate and create value? What does this look like in the health services sector?
- **Community and environment** – How do we meet our stakeholder expectations? Can we take advantage of opportunities (and avoid risks) as they arise? How do we manage ‘bad news’ (such as a service no longer being offered)?

Using a balanced scorecard approach, health services set themselves goals and measures for each perspective. These should be directly aligned to the Strategic Plan and the SoP. The board then selects the measures that best calculate progress in achieving these goals. These goals and measures should be geared to the circumstances of individual health services.

The balanced scorecard provides a performance information framework that allows health services to evaluate the effectiveness of their strategy and meet their ministerially appointed obligations under the Enabling Act. The balanced scorecard methodology has been promoted mainly as a management process, but it makes an excellent reporting framework for health service boards.
Useful references

- Nadler Advisory Services, Engaging the Board in Corporate Strategy: A value add approach, White Paper, Mercer LLC. Available from: http://nadler-leadership-advisory.com/NAS-White-Papers/7_Engaging-the-Board-in-Corporate-Strategy.pdf [Note: site registration may be required to access white papers].
- DHHS. Health 2040: advancing health, access and care https://www2.health.vic.gov.au/about/health-strategies/health-reform
7. Risk management

Boards are responsible for ensuring the health service is sufficiently agile to respond to changes in both its internal and external environment. Effectively understanding and assessing a health service’s risk landscape can turn potential clinical, financial and reputational challenges into strategic opportunities.

Questions that directors of health services should ask

- Are the relevant roles and accountabilities for risk properly formalised and documented?
- Are assurance activities based on appropriate and robust structures and aligned to the risk profile of the organisation?
- Does the board appreciate the potential consequences of serious risk and governance failures?
- Are there early warning systems in place to alert the board and senior management to emerging risks?
- Is there integration of risk management with strategic direction and planning? Are risks related back to the core goal of delivery of safe, high quality care?
- Are the right risks being identified, assessed and managed?
- Does the board challenge the risk approach, risk reporting and management plans?
- Does the board provide oversight on plans for crisis management and business continuity?
- Is the board establishing the ‘tone at the top’ to reinforce and promote a risk aware and positive reporting culture?
- How is the board updated on changes to the laws and regulations relevant to the health service?
- What is our communications and social media strategy for managing a crisis or emergency?

Red flags

- Risk management is not connected to the health service’s strategy.
- Leadership from the top is lacking.
- Risk management is positioned as a compliance and backroom exercise.
- Risk reporting and risk management plans are not challenged at board level.
- A healthy risk culture is not embedded throughout the organisation.
- The risk register is very brief and does not contain relevant risks.
- The risk register is not regularly reviewed by the board.
- The board and management are constantly responding to unforeseen events.
- Directors are unable to identify key risks for the health service when asked.
- The board is unwilling or unable to respond to risk issues.
- The escalation process for bringing risk issues to the board is not clear or staff do not feel comfortable reporting risks.
Introduction to the chapter

Health services are inherently risky. It is the role of a health service to take on clients in some form of medical distress or in need of care. The very nature of this purpose adds to the risks any corporate entity would face. Risk management is the flip-side of strategy. All health services must operate with a certain level of risk. This chapter looks at:

- key risk concepts and how they manifest in the Victorian health sector
- key elements of effective risk reporting
- the board and CEO’s role in overseeing risk within the health service - and how they differ.

Defining risk

Risk and risk management can mean different things depending on the context. The following high-level definitions are provided to assist in interpreting some of the issues discussed in this chapter.

- **Risk** - the chance of something happening that will have an impact on objectives. It is expressed in terms of the consequence of an event and the associated likelihood of occurrence.\(^93\)
- **Risk management** - the culture, processes and structures that are directed towards the effective management of potential opportunities while managing the potential adverse effects.
- **Enterprise-wide risk management** - an organisation-wide approach to the identification, assessment, communication, and management of risk in a cost-effective manner – a holistic approach to managing risk.
- **Risk governance** - incorporates the processes necessary to bring reliable risk management information to the attention of the board.

Effective boards consider the robustness of risk governance systems, understand how they work, and to what extent they can provide them with assurance.

Risk in the Victorian public health sector

Risk management is a significant responsibility of the board, requiring directors to ensure that robust monitoring frameworks, policies and procedures are implemented by the executive team.

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\(^{93}\) Please refer to AS/NZ ISO 31000:2009 Risk Management - *Principles and Guidelines.*
Health services should:

- monitor the performance of the health service to ensure effective and accountable risk management systems are in place. This includes financial, strategic and clinical risk management in accordance with the relevant Victorian Government guidance.

- ensure the Minister and Secretary are informed in a timely manner of any issues of public concerns or risks that affect or may affect the health service.

In addition to any specific requirements under the Enabling Acts, there are similar requirements for managing risk in the public sector that fall under the FMA. The FMA requires that boards and CEOs implement and maintain risk management governance, systems and reporting requirements contained in the Victorian Government Risk Management Framework (VGRMF). Section 81 of the PAA also requires that boards notify the Minister of “known material risks” that could impact on the health service.

Victorian Managed Insurance Authority (VMIA)

As discussed above, the VMIA provides risk advice and insurance services for the Victorian Government and its entities.

As the State’s insurer, the VMIA has developed tailored insurance products which covers most aspects of Government operations and infrastructure, including not only hospitals, but also schools, roads, rail, buildings, as well as people, for example doctors and nurses.

The VMIA regularly conduct training programs, seminars and educational events on current and emerging topics in insurance and risk management. As providers of insurance services to the public health sector, they have a strong understanding of the risks health services face – and are therefore a valuable resource for all health service directors and executives.

VMIA is a Statutory Authority established by the Victorian Managed Insurance Authority Act 1996 (Vic) and is a successor in law to the former State Insurance Office.

VMIA’s core business is in two areas, prevention and recovery, helping:

- the State prepare for, prevent or reduce the impact of harm (prevention)
- government agencies restore services and recover quickly (recovery).

Prevention

One of the VMIA’s focus areas is as a risk management adviser; allowing health services to deliver programs and services for the Victorian community by assisting them to better understand and manage risk. Having effective risk management in place helps health services make better decisions and improve performance, which is essential for developing and delivering safe, high quality services.

The VMIA undertakes client training focusing on building risk management capability through workshops, client training programs, forums, consultations and site visits. This allows health services to improve their capability in limiting their exposure to potential damage and disruption in service delivery.

The VMIA’s risk services and tools are informed by the VGRMF based on the current risk standard: AS/NZS ISO 31000:2009 Risk Management - Principles and Guidelines.

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Recovery

The other key area of focus is recovery. The VMIA restores services and repairs assets as quickly as possible to enable Victoria to recover quickly after a risk incident or event. For health services, this involves assisting with responding to incidents and crisis events promptly and efficiently. Additionally, it handles the majority of claims made against health services and adheres to model litigant guidelines considering it is a Statutory Authority.

Risk management roles and responsibilities

Role of the board in managing risk

The board is ultimately responsible for risk management. In practice, this requires boards to have a proactive approach to managing risk, particularly clinical risk management which is one of the five domains in the Victorian Clinical Governance Framework (refer to Chapter 2 in this Toolkit).

Risk is more than a compliance function. Risk is integral to strategy development and performance management – two other critical roles of a health service board.

A focus on risk, compliance and assurance is a key component of board performance. In the health context, this includes clinical and operational risk management planning, an effective internal audit program, well performing finance and audit committees and a compliance focus including legislative and regulatory compliance.

Effective risk management should be connected to strategy development and not be purely compliance focused. This requires the board to have continual insight into strategic, operational, financial, political and social landscapes that may impact or optimise the health service in achieving its strategic objectives.

From a process perspective, the board needs to:

- approve and regularly review and update the organisation’s risk framework including the risk management policy and the establishment of a risk committee
- receive regular updates about key risks and trends (from both internal and external sources)
- adopt early warning indicators and escalation protocols
- monitor compliance with the Victorian public health sector risk policies including financial, clinical, operational and strategic risks
- ensure that a comprehensive risk register of current and emerging operational and strategic risks, is maintained and regularly reviewed, challenged and updated by the board.

Board responsibilities for managing risk are outlined under the relevant Enabling Acts, and may require that boards ensure that effective and accountable risk management systems are in place.

Role of the CEO in managing risk

The board and CEO must liaise with DHHS in managing their health service’s risk to ensure there are no surprises. Under section 81 of the PAA, ‘major known’ risks must be identified to the Minister, for example, the resignation of the health service’s CEO.

The HSA specifies the responsibilities of the CEO include, amongst other things, the obligation to inform the board (and Minister/Secretary) of any risk that is likely to affect the health service. In practice, the

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Risk management / 166
CEO’s role is critical. They must implement the board’s risk policies and processes in such a way that the key risks are proactively managed and responded to in a timely and effective way, so as to minimise any negative effects on the provision of health services.

**Risk and strategy**

In any organisation, there is an intrinsic link between the development of strategy and the risks that threaten its achievement. Despite the benefits of integrating these two key processes, many health services struggle to do this. However, integration is essential if health services are to extract the most out of both strategic and risk management processes.

Experience suggests that health services that make risk management an integral part of their strategy are more resilient in dealing with adverse events and uncertainty. Poor management of material health service risks has been widely reported in the media.

**Risk appetite**

Risk is inherent in any organisation. This is particularly true for a health service where clinical risks, for example, can result in significant injury and death. All health services must be aware of, accept, and appropriately manage some level of risk. Risk appetite is the amount of risk, on a broad level, that an organisation is willing to accept in pursuit of value. Any organisation, including a health service, cannot operate – and therefore fulfil its purpose – without an appetite for some level of risk.

The organisation’s risk appetite will reflect the risk management philosophy and the health service’s capacity to take on risk. It will be based on the agreed strategic objectives and stakeholder demands for the organisation. The notion of risk appetite can add discipline and focus when responding to an uncertain and constantly shifting risk environment. A risk appetite statement can provide a decision-making framework for the strategic and operational handling of risk.

**Risk framework and governance**

Risk governance incorporates a range of elements that together provide a framework for managing and monitoring risk. Risk governance comprises the processes necessary to bring reliable risk management information to the attention of the board. It encompasses the overarching risk management structure to facilitate the management of risks across an organisation.

Key elements of risk framework include:

- a formal risk management policy, that defines the organisation’s risk profile and risk appetite
- procedures in place for identifying, assessing and categorising risk
- development of relevant measures and KPIs
- monitoring and reporting requirements to enable effective awareness of emerging and current risks (including escalation processes outlining when matters are to be presented to the board for review).

Being aware of all current and emerging risks is important for all boards and individual directors. It requires directors to be curious, to ask questions and to scan the internal and external environment for issues that could impact the provision of services and the obligations of health services under the Enabling Acts. Sources of information include:

- **Stakeholders** – formal or informal engagement with all stakeholders, including staff (both clinical and operational), DHHS, other health service providers, other governance practitioners
- **Media and public opinion** – keeping up to date on relevant media issues, topics and articles (including social media)
- **Legal/compliance register** – receiving regular updates that monitor and track changes in
relevant legislation

- **Obtaining and reviewing a range of data** - including quality of care/clinical data, financial results, asset condition assessments data, patient flow data or demographic trends, etc from external sources (such as DHHS, VAHI, Australia Bureau of Statistics, other emergency services)

- **Training and information sessions** – initiated by the board (often as part of strategy discussions) or operated by external providers (other health services, DHHS, professional organisations)

- **Regular review of risk** - the risk register should be a regular agenda item on the annual board agenda, with the register being tabled every six months.

**Risk reporting to the board**

Many board committees (e.g. Audit and Risk, Finance, Clinical Quality and Safety, etc.) have oversight responsibility for the health service’s enterprise risk management process, as well as other major risks facing the organisation – including clinical, financial, policy and operational risks.

Risk reporting from these board committees should be aligned to provide transparency in reporting of risks to the board. Board reporting should include formal linkages to key risks outlined in the organisational risk profile and risk register, as well as risk mitigation strategies.

Refer to Appendix 6 for examples of board risk reports.

**Key risk areas for health services**

Health services face similar risks to many other organisations including:

- **Organisational risk** – risk associated with the operational performance of the hospital including management of staff, IT systems, procurement, etc.

- **Financial risk** – risk associated with the viable operations of the health service, including funding sources, cost efficiencies, fraud and financial performance

- **Legal/compliance risk** – risk associated with non-compliance with relevant legislation including the Enabling Acts, accreditation standards/requirements, FMA, work health and safety, privacy etc

- **Physical/asset management risk** – risk associated with owning and operating physical assets including health and safety, reliability of service (in relation to clinical care) and asset exposure (e.g. bushfire/flood and disaster recovery/business continuity).

**Clinical risk (quality and safety)**

In addition to the above, health services have the critical and unique addition of clinical risk.

Specifically, health services are required to report on clinical risk structures and activities annually as part of the Victorian Quality Account.

Effective management of clinical risk requires that systems and processes are put in place to identify and prevent harm to patients. All health services are required to implement locally based clinical risk management systems, or to enhance their existing clinical risk management systems, in line with the

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**Clinical (quality and safety) risk**

Clinical risk management refers to the risk associated with clinical practices and the provision of safe, high quality care that is person-centred for each consumer.

Managing this risk requires consideration of a range of issues including:

- organisational culture associated with provision of clinical care
- quality and condition of equipment and assets
- appropriateness of clinical skills and delivery processes
- effectively involving consumers in decisions relating to their care.
Risk management forms one of the five domains of the clinical governance framework and recognises that signs of successful clinical risk management include:

- quality and safety outcomes are monitored against external benchmarks
- trending analysis of data is conducted
- documented review of risks and mitigation actions reported to board at least quarterly
- performance regarding safety culture is reviewed
- the board receives regular reports regarding the progress on achieving organisational goals for safe, quality care for every consumer.

Health services are also required to implement an incident management review process consistent with best practice and their clinical governance policy, and in line with the Victorian Health Incident Management Policy.97

Clinical risk is covered in further detail in Chapter 1: Victoria’s health service governance and Chapter 2: Clinical governance.

Risk management policy

Risk management policies should reflect the organisation’s risk profile and should clearly describe all elements of the risk management, quality and assurance functions. The policy should be an instrument to communicate the health service’s risk-management approach and should include, at a minimum:

- a definition of ‘risk’ and ‘risk management’ relative to the health service
- goals and strategies for risk management
- the health service’s risk appetite/tolerance
- how risk management targets will be measured
- accountabilities for risk management.

Risk culture

Risk management implementation not only requires significant effort from a framework perspective, but also the creation of a risk management culture that is committed to managing risk within the parameters defined by the board.

Risk culture defines the behaviours (i.e. the ‘how we do things around here’) that support the framework (i.e. the ‘what we do around here’). It is the role of the board to develop and set the risk culture of any organisation. Key actions to establish a common risk culture include:

- communicating the end vision and benefits
- communicating the board vision, strategy, policy, responsibilities and reporting lines to all employees and stakeholders
- developing training programs for risk management
- identifying and training ‘risk champions’
- providing success stories and identifying quick wins

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96 DHHS, Governance for safe, quality healthcare, Victorian clinical governance framework, October 2016

• developing a knowledge-sharing system
• developing and assigning responsibilities for risk management
• providing a positive reporting environment and just culture.

Crisis management and communication

Emergencies and other unpredictable events can cause disruption of essential services and can leave you looking unprepared.

Effective and proactive stakeholder management is critical for crisis management, business continuity planning and disaster recovery.

Having an existing relationship and rapport with stakeholders, where good will is invested over time, allows you to draw from that pool like a credit line when a crisis or emergency presents.

Health services should have crisis management plans in place. Such plans should include reference to the board’s role during a crisis and should be considered as part of a board’s risk management responsibility. Boards should insist that crisis management plans contain a robust communications element. Without effective communication, health services may inflict additional damage on themselves including:

• losing control of the communications process
• allowing facts to be displaced by rumour and speculation
• reputational harm
• putting employee morale and trust at risk
• alienating shareholders, customers, suppliers and other stakeholders.

Contemporary risk management frameworks, including crisis management plans, should incorporate the mitigation of social media risk as a key function. Boards and senior management need to be prepared to manage and respond to social media.¹⁸

Further, and as mentioned above, the board and CEO must inform DHHS of risks in order to ensure DHHS and the health service can prepare and manage the message(s) in response.

Social media is a powerful tool to utilize in order to build trust with the community and consumers of your health service.

It is even more vital in emergency situations or a crisis where the speed of information (or worse, misinformation) can be in itself an asset or in itself a risk.

¹⁸ DHHS can provide guidance with respect to processes and protocols for managing issues that arise through social media, including how best to respond and the appropriate communication strategies. See also: OECD, OECD Reviews of Risk Management Policies The Changing Face of Strategic Crisis Management, (December 2015).
Using social media in risk and crisis communications

The OECD, in its working paper on the *Use of Social Media in Risk and Crisis Communication* (2013) identified 12 good practices for utilisation of communication channels such as social media during a crisis:

- Raising public awareness about risks and crises
- Surveillance, monitoring, situation awareness and early warning system
- Improving preparedness
- Providing information and warning
- Improving crisis response through mobilising volunteers
- Identifying survivors and victims
- Managing reputational effects
- Providing incentives to collect funding and support Learning from the crisis ex post
- Improving partnerships and cooperation between national and international players, between public and private actors
- Enhancing recovery management


Business continuity planning (BCP) and disaster recovery (DR)

Planning for a disaster is considered essential practice as all businesses face the risk of a serious event occurring that can damage the organisation’s ability to continue operating.

Business continuity planning is related to but not the same as disaster recovery. Business continuity is not just about bouncing back after a disaster – it is about how well you maintain access to and provision of critical services during a crisis or disaster.

Business continuity management focuses on an organisation’s responsiveness to an organisational or external crisis that puts its ongoing operation at risk. The aim is to foster and develop preparedness for all types of events that may significantly affect an organisation and enable it to respond and resume normal business operations after they occur.

Available here: http://dx.doi.org/10.1787/5k3v01fskp9s-en
The ultimate goal of business continuity is to develop a response to events to enable the organisation to maintain its most critical operations, and survive all but the most extreme forms of operational disruption. The key elements of effective business continuity planning are flexibility and simplicity.

A well-prepared organisation will be able to make the right decisions at the right time, based not on rigid instructions contained in a detailed manual, but on tried and tested alternative ways of working.

These arrangements must:

- be integrated into everyday business
- look inside as well as outside the organisation
- be understood by employees and stakeholders
- be regularly and effectively tested to ensure they remain relevant.

A crisis can develop rapidly and managing the messages around it can be crucial in effectively managing the impact and best serving the community.

A health service that neglects communicating and engaging with their consumers (including via social media) may risk a significant loss of trust and confidence when crisis strikes.
Stakeholder management plans for crisis situations and emergencies

Communications and stakeholder engagement plans are common for large projects and help the project owner to control the messaging. Health services should likewise have a crisis communication plan that describes key elements, including:

**WHO**
- Who are the key stakeholders that need to understand this message?
- Is it the public at large? Our staff? The department/Minister?
- Is it a single/simple group or a complex/diverse group of stakeholders?

**WHAT**
- What are the key messages of this health service? How does our message align with our health service’s values, purpose and strategic plan?
- Is this a matter we can have a public view on? (e.g. is it political/partisan?)
- Do we need to counter misinformation? What is the best way to do that?
- Have we checked our sources and the credibility/validity of the information before the health service puts its name against the material (e.g. via sharing or republishing)?

**WHERE**
- What is the right messaging channel for this?
- Which medium is the best placed to manage these communications?
- Is this something that we need to get out right now to everyone?
- Is this more of a marketing issue?

**WHEN**
- Is this crisis the sort that needs immediate commentary as it unfolds such as status updates?
- Is this something that should have additional oversight (e.g. a legal matter)?

**HOW**
- What is our process for communications oversight?
- What thresholds would trigger certain approvals?
- When should only the CEO communicate?
- When should it be the board chair?
- Should we contact/coordinate with DHHS?
- What approvals are needed? How are these fast tracked in an emergency?
Useful references

- VMIA website - provides useful risk management tools and information for health and Government agencies: https://www.vmia.vic.gov.au/risk
8. **Productive meetings**

Meeting of directors should be forums of informed discussion and decisions – not an endless stream of surprises or a lobbying space.

**Questions that directors of health services should ask**

- Is the number and length of board meetings sufficient to allow the board to effectively discharge its duties and responsibilities?
- Are previous meetings’ board minutes easily accessible for review prior to the next meeting?
- Is the board provided sufficient time to review the board papers prior to the next meeting?
- Is the chair clearly accountable for the agenda’s content? Do all directors and board committee chairs have the opportunity to contribute?
- Are the board’s communication channels secure and confidential?
- How clear are our values? How clear is our purpose (the why we exist which underpins our values)?
- What are our guiding principles (i.e. what helps us make decisions)?
- Is the size of the meeting group appropriate, having regard to the purpose of the meeting, and are all attendees directly relevant?
- Is regular feedback and evaluation of the effectiveness of meetings provided to board directors?
- Does the board manage actions arising from board minutes, with outstanding actions being reviewed at each board meeting?
- Is the board undertaking board self-assessment to identify opportunities for improvement?
- Has the board allowed sufficient time for committee reporting such that the board is satisfied delegated authorities are being executed appropriately?
- Is time dedicated to quality and safety at every meeting?
- What is the goal of my question(s)? Is this my goal or the goal of the entity?

**Red flags**

- Board or subcommittee meetings are not scheduled on a regular basis.
- Meeting agendas and materials are sent out with little time for review or director contribution.
- No time is spent reviewing clinical data/domains at each board meeting.
- Directors do not read board papers prior to attending the meeting.
- Board papers are voluminous and don’t always relate to the key agenda items.
- The chair provides incomplete or untimely distribution of board meeting minutes after meetings (more than 24 hours after).
- Many issues discussed carry over to the next meeting without an agreed set of actions.
- Attendee and absentee lists are kept irregularly and sometimes are not noted in the minutes.
- Directors attend less than 75 per cent of meetings held.
There is no information sharing portal set up for the board and directors rely on emails and handouts to communicate and store information.

Board meetings only ever include the CEO, with no other executives or staff, external specialists or guests attending to discuss new and emerging issues relevant to performance, strategy development and/or risk management.

At the end of each meeting a review of the effectiveness of the meeting is not undertaken before closing.

The board does not hold, or consider holding, ‘in-camera’ meetings where directors meet behind closed doors, without management or any other non-board director present.

‘In camera’ sessions are used inappropriately with no clear reason for being held.

**Introduction to the chapter**

Boards only get together every 4-8 weeks, meaning that the limited time available needs to be productive and effective. This chapter looks at:

- what makes a board meeting effective
- guidance with respect to making board papers more targeted and meaningful – and enabling directors to better meet their responsibilities.

Hospital boards also have a crucial role in safety and quality. Boards help set the tone of an organisation’s corporate culture. They can set priorities for safety and quality alongside financial management, and hold the CEO and other staff accountable. They can signal the priority they place on safety and quality by the time allocated at board meetings, diligence in questions asked and their supervision practices generally.

-Targeting Zero report, page 24

**Effective and productive board meetings**

The roles and responsibilities of the board involve risk, strategy, stakeholder engagement and setting the organizational culture.

The key forum in which all this happens is the regular board meetings. Meetings are often held monthly and may only be 3+ hours in duration. It is therefore important the meetings are productive and effective in order for the board to get through full agendas, ensuring that all key areas and responsibilities are covered.

**Directors**

Directors are expected to prepare for, attend and contribute meaningfully to board meetings in order to discharge their director duties. Directors must understand the time commitment of serving on the board of a health service, including taking the time to prepare and attend all meetings of the board and board committees held during the year. A minimum attendance of 75% is a requirement of the appointment.

Productive meetings / 176
There are many elements that make a meeting productive. Some involve mechanics such as meeting frequency and board papers, others related to skills, conduct and behaviours of board directors. These are outlined in Figure 8-1 below.

**Board chair**

For most health service boards, the board chair is appointed by GiC on the Minister’s recommendation. For public hospitals and MPS the board chair is elected by the members, however, the HLA Bill will enable the Minister to appoint a chair if the Minister deems it appropriate.

The chair plays a central role in the effective functioning of meetings, maintaining responsibility for leadership of the board and its efficient organisation and functioning. The chair is responsible for setting the board agenda and ensuring adequate time is available for discussion of all items. It is important the chair leads discussions, encourages participation of all directors, and conducts meetings in an effective manner.

When a topic has been fully discussed, the chair should summarise the discussion and seek the agreement of the board (or hold a vote). The chair must also ensure the board’s time is used to focus on the most important issues.

More details regarding roles and responsibilities of the chair and other office holders are provided in Chapter 3: Conduct, Ethics and fiduciary duties and Chapter 4: Statutory duties.

**Board committees**

Board committees provide an effective way of distributing work between directors and allow for more detailed consideration of important issues than would be possible during scheduled board meetings. Committees allow directors sufficient opportunity to focus on relevant matters without having to compromise the limited time available during full board meetings.
Each committee should appoint a chair, who is ideally not the chair of the board. Subject matter experts and advisors can also be appointed as committee directors, however they too should not be appointed chair.

The purpose of any committee is to make recommendations to the board on specific matters (defined under the committee’s terms of reference). Some committees may be ongoing, whilst others may be established for a short time only, to deal with a specific working matter of the board that requires particular focus or additional formal consideration outside the boardroom.

Under the Standing Directions of the Minister for Finance of the FMA, all boards of public sector entities, including health services, must establish an audit committee. Furthermore, boards of metropolitan and major regional health services are required to establish three committees: finance, audit and quality committees. Whilst the Enabling Acts do not specify that boards of other health services must establish those committees, good governance suggests all health services adopt this (or a similar) structure in order to prevent a possible breach of their director’s duties.

The Government’s executive remuneration policy also requires all boards to establish a remuneration committee comprising of at least three directors. The role of a remuneration committee is to determine the health service’s policy and practice for executive remuneration, and the individual remuneration packages for its executives.

The Enabling Acts require boards of metropolitan and major regional health services to appoint a primary care and population health advisory committee, and a community advisory committee. Boards are also permitted to appoint other advisory committees under the Enabling Acts as they deem fit.

Refer to Chapter 5: Board structure and renewal and Chapter 4: Statutory duties.

Boardroom conduct

While each board will have its own particular boardroom style, there are basic principles of good boardroom practice and etiquette:

- punctuality and attendance for the full meeting
- full attention should be given to listening and contributing to the discussion
- well-timed and adequate breaks should be scheduled, and catering provided, especially for long meetings
- professional, respectful and collegiate behaviours aligned with the expectations of directors of public sector health services.

Procedure and the degree of formality of meetings is up to the board. These procedures and forms of etiquette should be sufficiently documented and provided to new directors at orientation.

Boards should also have a conduct charter, which includes dispute resolution and behaviours expected of directors. A model conduct charter is available on the Health

Effective codes are: Institutional and symbolic

Within institutions codes articulate boundaries of behavior as well as expectations for behavior. That is they provide clear markers as to what behavior is prohibited (bribery) and what behavior is expected (showing impartiality to all citizens).

They are also highly symbolic. Subscribing to institutional codes is the way we define a model professional not only as we see ourselves but as we want to be seen by others.

-Gilman, Stuart C, Prepared for the PREM, the World Bank in 2005 (refer to references for full details).
More information on director conduct is in **Chapter 3: Conduct, ethics and fiduciary duties**, **Chapter 4: statutory duties** and **Chapter 11: Organisational culture and leadership**.

### Meeting procedures and conduct

The board is responsible for establishing its own procedures for board meetings, which should be documented within the health service’s by-laws or governance policy. The board must agree on the frequency and duration of meetings, together with the processes for effective decision-making.

A board should establish clear meeting procedures based on governance of principles of transparency, integrity, honestly and accountability. The board should structure regular meetings to monitor strategy implementation, risks and operational matters and make informed decisions in these areas.

#### In-camera sessions

In-camera sessions are ‘director only’ meetings where executives, guests and other non-board directors are not in attendance. They are useful for discussing issues such as:

- CEO performance and remuneration
- relationships between directors
- relationships with management and assurance providers
- director performance issues (both individual directors and the board as a whole)
- ‘tone at the top’ concerns
- protected disclosure issues relating to senior management
- confidentiality or sensitive issues affecting management and/or assurance providers
- potential conflicts of interest
- independence concerns relating to assurance providers.

It is recommended to have in-camera sessions at each meeting as a standing agenda item allocating about 15 minutes. This ensures that requesting the in-camera session does not become a barrier in and of itself to a positive disclosure culture. If there are issues raised with the chair prior to the meeting, more time can then be allocated in

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advance.

Whether there should be minutes of an ‘in-camera’ meeting is up to the board and will depend on the nature of the discussion. Some organisations allow their minutes to simply state that an ‘in-camera’ session should be documented, allowing outcomes to be tracked in subsequent meetings.

**Director’s boardroom behaviour**

Good boardroom debate will ensure that different views are tabled and discussed in an open, collegiate and respectful way. However, often issues discussed and decisions made in the boardroom involve compromise of an individual’s personal views.

Disagreement is common and healthy for a board, however, the chair must manage both the range of views and time allocated to any one issue. This means that directors need to defer to the chair’s authority rather than make the already difficult task harder. In doing this, directors need to remember that the chair’s role is to ensure the board fulfils its role. This means that sometimes a topic one director is passionate about has to be moved on or taken offline. It may mean that the chair calls for a vote to decide the issue. It may appear, if the issue is something you are passionate about, that the chair has simply moved on or dismissed the issue; this is likely just the chair keeping the meeting on track to ensure that all issues and views are discussed in the allotted time, not just the one you are passionate about.

Significantly, decisions of a board are group decisions. Even if you as a director disagree, it is not a case of you being right or wrong. Joint decision making as a group means that there is a very real possibility of a decision going in a direction you disagree with.

In situations where you as a director strongly disagree with a proposed course of action, it is important that you:

- **Properly prepare** and ensure you understand the agenda item and/or the proposal.
- Make sure you have considered **how the proposed action fits in with the goals and purpose of the health service**. Ask yourself, is your concern consistent with the health service’s goals and purpose? Remember, it is not about you or what you did when you were in a past role.
- Where the concerns are evident in the papers (i.e. before the discussion), raise it **with the chair prior to the meeting** to enable further information from management to potentially address your concerns and/or inform the discussion.
- **Keep calm and respectful.** Remember you are one view of many. Seek to listen to others rather than simply waiting for your chance to speak or talk over them.
- **Ask questions.** Don’t just assume you are right. Ask yourself, what is the goal of this proposal and the goal my questions seek to understand?
- In the meeting, **take your cues from the chair** – the chair is managing all the views in the room, not just yours or the view opposed to yours.
- **Take any caution regarding your behaviour seriously.** The chair will take into account that debate can be robust, passionate and even lively. The chair is, however, expected by all directors to call out inappropriate behaviour.
- **Remember how hard the chair’s job is,** particularly in navigating the space between ‘robust’ or ‘lively’ debate and disrespectful argument. Do not contribute to the negative, rather, assist your chair by following his/her instructions.
- If you still retain significant concerns that you feel were not understood at the meeting, ask to **speak to the chair about it offline.** The chair will be able to provide an opportunity to discuss each director has an individual responsibility to ensure that their conduct reflects the importance of the office and the responsibilities and privileges that they have been given.
the matter in more depth and potentially with the executive that presented the item.

More information on boardroom behaviour and the critical role of the Chair is in *Chapter 11: Organisations Culture and Leadership*.

**The role of the board chair**

The board chair is the ultimate leader of the organisation and as such, needs to have all of the attributes of a good leader and of a good board director. The chair presides of the meeting and facilitates debate and discussion to enable a matter to be decided on by the group.

The chair must have a strong working relationship with the CEO but must also maintain their independence from the executive. This means the chair is required to both challenge and support the CEO and facilitate exploration of issues for the board.

A board chair should strive for consensus and guide the board to their decision, rather than simply make decisions for them. The board chair is responsible for creating a culture and an environment where all directors feel comfortable and safe to contribute, challenge others and reach a decision as a group.¹⁰¹

**Inclusive leadership**

The chair plays a critical role in facilitating effective boardroom dynamics. Robust, effective discussion should not be confrontational or be dominated by a select few. The chair’s role is to understand the different personalities on the board and ensure that everyone participates equally in the discussion.

This requires strong communication skills and emotional intelligence to that need to be challenged, conflicts as they arise, and identify what was not said (or who has not spoken) to ensure all views are heard.

It is the chair’s role to ensure that all directors are able to contribute and bring their best self to each meeting. That means that the chair needs to have a good understanding of director personalities, experience, expertise. Each board director is there for a reason and the chair’s role is to utilise that for the maximum benefit of the health service. This enables the range of diverse views to properly interrogate the subject matter and come to the best decision available from the information known at that time.

**Managing director conduct**

An old saying in the health arena is ‘prevention is better than cure’. This holds particularly true for board culture and managing conduct of directors. As such, the first step in managing director conduct is having systems and processes already in place. These include:

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¹⁰¹ *Leading Governance, 10 Attributes of a great chair*, (2013), Leading Governance Ltd, Belfast.
Role modelling values based conduct

Being honest and act with integrity

Have a conduct charter in place so that you can refer to that in difficult discussions. If the board does not have a conduct charter, the chair can refer to the Directors’ Code of Conduct102

Meet with board directors one-on-one and make all directors feel valued.

On those occasions the chair is required to step in (to correct behaviour), the chair should model the values and conduct they wish to see. This might include acknowledging strengths and passions while also reminding the director of their tone and/or refocusing the discussion on the health services’ goals. This is not an easy task and directors should actively support their chair in fulfilling this role.

It is critical to keep in mind that directors serve on the board of a health service due to a range of benevolent motives, including believing in the purpose and work of the health service. Health services, at their core, exist to provide high quality, safe clinical services to people in distress and need. This benevolent and critical purpose of health services for the community, mixed with beliefs and personal experiences can generate a level of passion in the discussion. Given this, the first step for a chair to manage director conduct is to remember and acknowledge the in many cases the source of the conduct may be passion rather than simply acting out.

Passion and commitment, even for the best of causes, are not an excuse for aggression, talking over people, dominating the conversation, bullying or harassment. Even if the director is ‘right’, conduct must remain respectful, courteous and take guidance from the chair. Board discussions are not about winning or losing, they are about arriving at a place for a decision having properly tested the options and issues. This can only occur in an environment where all parties feel safe to contribute.

In order to manage poor conduct, the chair must understand his/her individual directors and where they are coming from. A good chair is sensitive to that passion while moderating conduct to maintain a place that is safe for all to challenge viewpoints and disagree.

If a dispute arises in response to poor behaviours, or any other alleged breach of the health services conduct charter, by one or more of the directors, the chair must work with the relevant individuals to find a constructive solution. Importantly, the chair must be careful to role-model values based conduct when correcting director behaviour, particularly if it has to be done during the board meeting. Like any supervisor relationship, the chair should be careful to maintain the dignity of the director being corrected.

More information on boardroom behaviour and the critical role of the Chair is in Chapter 11: Organisations Culture and Leadership.

“Respect and trust do not imply endless affability or absence of disagreement. Rather, they imply bonds among board members that are strong enough to withstand clashing viewpoints and challenging questions.”

- Jeffrey A Sonnenfield, What makes great boards great, (September 2002), Harvard Business Review.

Decision-making processes

The emphasis in the boardroom is on consensus decision-making, which focuses on securing the agreement of the full board. If unable to reach a consensus, the board should state the reasons for this and endeavour to solve the issues or find further information required to make a decision. It is the role of the chair to lead and direct the decision-making process, ensuring that consensus is reached or, if not, there is a clear way forward.

A board should have a set of **guiding principles** to help them make decisions.

These guiding principles should be based on the health service’s **values** (what we believe) and **purpose** (why we are here).

The board must consider all aspects of an issue and seek necessary advice to assist directors in understanding the full implications of the decisions they make. The board should ensure the decisions it makes are legally valid, compliant with Government policy, and are ethically sound and fair.

The following elements (at a minimum) should be considered for informed decision-making:

- alignment with strategic direction
- financial and reputational impact and considerations
- economic and financial assumptions
- key risks and dependencies
- availability of resources (internal and/or external)
- ethical and environmental dimensions
- stakeholder perspectives
- description of due diligence completed
- benefits or outcomes are measurable and can later be tested
- contingencies to deal with unexpected developments
- monitoring and accountability mechanisms.

It is common practice for a resolution to be agreed by the board without a formal motion or vote. Instead the chair leads the board discussion around the recommended resolution proposed by management and agrees whether or not to endorse that recommendation.

In some instances, a board prefers that a motion have a second director to indicate support for it – known as a ‘seconder’. A motion that cannot attract a seconder fails.

“**The upshot wasn’t that the board won and management lost, but rather that, after passionate disagreements had been voiced, together they arrived at new conclusions.**”

- Jeffrey A Sonnenfield, What makes great boards great, (September 2002), Harvard Business Review.

**Decision-making outside the boardroom**

In some situations, decisions need to be taken before the next scheduled directors’ meeting. It is usually permissible to circulate a resolution for approval by directors without the need to convene a meeting, though this process should be reserved for urgent matters or more procedural matters.
Unless the health services by-laws provides otherwise, the resolution must be signed by all directors entitled to vote on the matter and it is deemed as passed when the last director has signed. Separate copies of the document may be used for signing, provided the wording of the resolution and statement is identical in each copy.

Once the resolution has been passed, it must be entered into the minute book and noted at the next meeting of directors.

Meeting preparation and attendance

Regular and consistent attendance at board meetings and adequate preparation prior to meetings are fundamental elements to ensuring productive board meetings. It is important that all board directors are sufficiently informed in relation to ongoing discussions and issues from previous meetings, as well as agenda items for upcoming meetings, in order to contribute meaningfully.

Meeting preparation

Careful preparation of the agenda enhances the board’s productivity and supports its strategic and oversight role. The board meeting should be an opportunity for directors to add value to the discussion and not be informed on the issues for the first time.

The purpose of the meeting should be communicated amongst directors in advance, allowing sufficient time to become familiar with the proposed agenda and undertake any research required. In order for a meeting to be productive, a strategically defined purpose should be linked to specific plans and outcomes. Meeting papers should be circulated well in advance of the meeting to allow board directors adequate time to review the materials and information provided for discussion.

Meeting attendance

As part of their duties and responsibilities, directors should be present for all board and relevant committee meetings. Absenteeism does not excuse a director from their duties to the health service. To facilitate participation, directors may attend in person, via tele- or video-conference per the procedures established by the board.

Serving on a health service board requires a substantial time commitment, including attending meetings of the board and board committees, preparing for meetings and ongoing self-education to assist directors perform their role and meet their fiduciary duties under the Enabling Acts.

Directors are required to attend at least 75 per cent of board meetings held during the year. This is, however, the minimum required. Directors are expected to attend all meetings unless there is a reasonable excuse. Directors who are unable to attend should ensure their apology is given in advance and it is noted in the minutes. If there are repeated director absences, the chair may need to meet with the director to ascertain their future availability and commitment. In some circumstances, it may be in the health service’s interest for the director to resign or be removed.

Meeting frequency and duration

Commonly boards hold monthly meetings. The length of the meeting should be sufficient to give appropriate attention to all issues at hand. When planning the agenda for a long meeting, it may be useful to consider whether splitting the meeting into two shorter meetings would be more appropriate. If the meeting must be kept to a single session, scheduling breaks is vital to keep participants focused, attentive and productive.
The board must ensure that the CEO convenes an annual meeting of the health service between 1 July and 31 December.

**Board papers**

Board papers should consist of concise documents that fully present the information the board will require in order to comprehend all the issues and make appropriately informed decisions. This includes reports presented to the board from a variety of sources, including from the CEO and committees. Poor papers are a major cause of bad board decision-making and difficulty in reaching a consensus. To facilitate effective decision-making, board papers should be:

- prepared to strict standards in terms of presentation and content
- share a consistent format
- include the date, version reference, author’s name and title
- subject to appropriate review, challenge and approval from a completeness, accuracy and data integrity perspective, and to ensure consistent messaging is provided to the board.

**Reports**

Reporting to the board from various sources should clearly articulate key issues across the health service, and include sufficient information to allow the board to make an effective and informed decision. Reporting should be:

- clearly aligned to the following principles to enable the board to efficiently discharge their responsibilities:
  - strategic priorities, risks and impacts to the organisation
  - board accountabilities
  - organisational business plan
  - key clinical, financial, operational and workplace performance indicators and metrics
  - accreditation requirements, where appropriate.
  - action oriented and clearly outline and track remediation plans in response to non-achievement of actions, strategies or expected performance outcomes
  - clearly state the action and/or decision required by the board (e.g. for noting, for decision, etc.)

**Agenda**

A board meeting agenda enables directors to be fully informed of issues to be proposed and discussed at the meeting, reducing the time required on briefing at the beginning of a meeting. It should be referenced to the annual agenda, which identifies matters to be periodically included on the board agenda.

Directors should **declare all interests** relating to matters on the agenda (or matters that arise in discussion), not just the interests they believe are in conflict.

The annual agenda is an important planning tool to ensure that all compliance, strategic and operational board matters are considered on a regular and timely basis. An annual agenda is essentially a calendar of issues to be discussed throughout the year, such as strategy review/renew, remuneration, annual reporting, election of officer holders etc. An example annual agenda is provided in Appendix 6.
The chair is accountable for the agenda’s content. Input into the agenda should be sought from directors, the CEO and senior management, and the chairs of committees. Directors should not be passive in this process. Directors should actively consider the agenda in advance to:

- identify any potential interests that may be in conflict
- identify issues that may need further information from management
- consider if adequate time is allocated to an item, particularly if that director sees risks in the item that have not been addressed in the papers
- consideration of if the minutes and actions arising from the prior meeting are accurate
- seek items to be added to the agenda.

Setting the agenda should involve a consideration of content, the ordering of items, the allocation of each item and deciding on appropriate invitees. High-priority items should be scheduled first and it is essential to clarify which items are for decision, discussion, noting or information purposes. A timed agenda will assist directors in recognising the relative significance of each issue and ensure the meeting finishes on time.

Standing agenda items should include:

- attendance and apologies
- privacy and confidentiality requirements
- declaration of interest and if these present a potential conflict (actual and perceived) at the outset of the meeting
- outstanding action items from prior meetings
- quality and safety.

When preparing the agenda, the chair should consider any potential conflicts of interest that may arise as a result of the matters being discussed. Any personal interests should be declared annually by all directors under the DPI requirement of the VPSC. Any items that potentially raise a conflict for any director should be raised by the chair with the director. If a conflict is apparent, board papers should be withheld from the conflicted director on that particular item for discussion. Additionally, the conflicted director should not be present when that item is discussed.

An example board meeting agenda is provided in Appendix 6.

**Board minutes**

The board chair, one of the directors, or the board secretary is responsible for drafting the minutes of the meeting. A draft of the minutes should be provided to the chair within 24 hours, and circulated to board directors no later than a week after the meeting. The minutes should always be formally approved at the next meeting if they have not previously been formally approved by all directors of the board. If the minutes are amended at the next board meeting, this should be reflected in the minutes of the subsequent meeting. It is the responsibility of all directors to ensure the minutes are accurate.

Minutes should be compiled very carefully, and with due regard to their potential use as documents with legal significance in instances of litigation. In this regard, it is essential for directors to give the process of reviewing and approving the minutes the level of attention it warrants, rather than simply treating it as an administrative exercise. Once signed, minutes are evidence of a proceeding, resolution or declaration to which it relates.

**Board solidarity**

In all cases, regardless of the issues, board solidarity outside the board meeting is an imperative. Without it, directors will lose the confidence to voice their views.

Differences of opinion aired during the decision-making process must not be aired outside the boardroom.
Where there is a controversy or critical vote, it may be reasonable to note who voted in favour (or not) of a proposal. However, it is not usual practice to provide reasons for the dissenting view in the minutes as this could breach confidentiality of the board deliberation and undermine public confidence in the board’s decision. The board can, however, as a group decide what should and should not be noted in the minutes.

Minutes should be prepared and distributed to board directors after every meeting in a consistent format. Minutes are a key element of the governance framework and must be developed as documents to evidence decisions made, key issues considered and adherence to due process. It is therefore critical that minutes accurately reflect the outcomes of each board meeting.

The level of detail included in the minutes will vary. The minutes typically include the following:

- meeting location, date and commencement time
- board chair and attendees names, including those physically present and those participating through the use of technology, what period and whether anyone left the meeting for conflict of interest reasons
- any apologies for those unable to attend the meeting
- directors’ DPIs
- each agenda item
- the outcome of each discussion of an agenda item or paper, with a record of any dissenting viewpoints and the reasons for the decision
- any new procedures or policies agreed by the board
- title, version reference and date of all papers tabled
- directors’ disclaimers or objections
- actions to be taken, including outstanding issues to be progressed and re-considered at the next meeting
- closure time
- a signature block for the board chair to sign the minutes at the following meeting when directors have approved the minutes.

An example board meeting minutes template is provided in Appendix 6.

Board directors must review the meeting minutes for accuracy and completeness and have corrections formally made at the following meeting.

Meeting minutes must be provided to all board directors, but distribution to non-board directors is at the discretion of the board (with the exception of a delegate). At times, it may be appropriate for contributors to a meeting be made aware of a decision or outcome relating to papers they tabled.

Publication and distribution of minutes outside the board

It is recommended that boards put in place clear processes and criteria under which papers are distributed to non-board directors. Where board papers are distributed to non-board directors, the board must ensure privacy (names etc), legally privileged information and commercial-in-confidence information is protected.

It is up to the board if they make minutes public or not, however, consideration ought to be given to any legal of confidential matters that may need to be redacted prior to publication, for example, commercial in confidence matters or information pertaining to legal proceedings.

Access to meeting papers

Directors of health services are permitted to retain their papers at the end of a board meeting, but must treat them as confidential.
Technology is rapidly moving into boardrooms, with digital distribution of board papers becoming increasingly widespread. Electronic communication methods may facilitate the exchange of timely and accurate information between board directors. The adequacy of the security of data sharing and storage technology (email, iPad and Dropbox-type applications) should be carefully considered when exchanging highly sensitive and confidential information. The use of online portals for hosting board papers and other organisational materials is growing substantially as a secure and efficient way of facilitating the board process. Electronic delivery allows relevant information required for decision-making to be delivered rapidly and economically.

The way in which directors access information has changed. Most directors use tablets and access a portal for board documentation.

Directors who utilise tablets claim it greatly improves their ability to prepare for meetings through reading and marking up board papers on the screen, and in recording and sending minutes instantly. Each director has access to the same information at the same time, no matter where they are, and are immediately able to review the information and collaborate further, if needed. The interaction of tablets and web-based board portals makes for an efficient and easy way to store records long-term, thus freeing up physical office space.

Tablets can include multiple layers of authentication and encryption to offer a considerable security improvement over traditional hard copy distribution. However, professional advice may be warranted regarding security and document retention concerns.

**Technology**

A board meeting can be called or held using any technology, provided that all directors consent. This is obviously useful when a director cannot physically participate in a meeting. Emergency meetings called at short notice are a case in point. Whilst the use of meeting technology, such as tele- and video-conferences, can eliminate many hours of travel time for directors located interstate or overseas, face-to-face meetings are generally preferred, especially where contentious matters are to be discussed.

It is fundamental where technology is used, that it is secure (particularly given the sensitive nature of discussions), reliable and fully functional.

Boards should also put in place protocols and etiquette expectations for technology use, including how the chair will include those participating via phone and use of mobile phones during meetings. In general, mobile phones should not be permitted during a meeting without specific permission as it distracts from the meeting.

**Confidentiality and Security**

Consistent with their fiduciary duties, directors are expected to maintain confidentiality of the deliberations of the board and its committees. Confidential board papers must remain secure. It is recognised as best practice for directors to return meeting papers to the chair after the meeting, who will then arrange for the secure destruction of surplus copies.

Several fundamental security recommendations include:

- encrypting documents
- installing password-protection mechanisms for all electronic equipment
• activating automatic locking of screens on electronic devices after periods of inactivity
• careful use of PINs for conference calls.

Duty of Confidentiality

The Directors’ Code of Conduct reiterates the fiduciary’s confidentiality requirements:

• directors must use the information only for its intended purpose
• directors respect confidentiality and use their discretion, prudence and good judgement when deciding how to treat information
• directors only disclose official information or documents when required to do so by law and do not express personal opinion on official policy or practice
• directors are able to make a protected disclosure to IBAC if they believe improper conduct is occurring within the public entity
• directors do not leak information internally or externally.

Independent professional advice

When one or a number of directors has concerns about the advice given to the board in relation to an issue, the board may need to seek independent professional advice to facilitate effective decision-making and to properly discharge its responsibilities. Independent advice means that of a third party and does not include reliance on an individual director’s qualifications (e.g. independent legal advice refers to the legal counsel of the hospital not a legally qualified board member).

The board has authority to obtain advice, reports or opinions from expert advisers, as deemed necessary, at the expense of the health service and subject to the written consent of the chair to seek such advice. Controls should be in place to ensure the process is properly managed and costs are proportionate and appropriate.

Board evaluation

Evaluating board meetings

Each board meeting should conclude with a review of decisions reached and the related actions, in order to increase accountability among directors. All participants should be fully aware of what is expected of them. Following the meeting, the board chair should ensure the minutes are circulated quickly in order to allow directors to promptly respond.

Requesting feedback on the meeting will provide valuable insights into how future meetings may be made more productive. Having an in-camera time at the end of all board meetings is a sound mechanism to obtain this regularly.

Meetings should also be evaluated from an effectiveness and efficiency perspective, with regard to both board director/chair conduct and behaviours, as well as decision-making capabilities. This can assist in ensuring respectful and functional board relationships are maintained by allowing board directors to reflect on boardroom conduct in real time.
Board and director assessment

A useful tool for obtaining feedback to further enhance the board’s performance, including meeting productivity, is to obtain an independent assessment. This can include surveys, questionnaires and observation of the board directors and meetings, combined with benchmarking to high performing boards. This process usually provides the board with a comprehensive report on performance, including strengths and potential opportunities for improvement. This also provides a statement to the health service’s staff and stakeholders that the board is proactively seeking feedback to drive continuous improvement.

Board assessment questionnaires (for board and individual director self-assessments) are available on DHHS’ website.103

Types of assessment

There are three main types of board evaluation and all will reveal different things about the board. It is recommended that any board evaluation include all three.

Full board evaluation

Evaluation of the full board seeks to assess how well the board is performing as a group. It can be useful to have an outsider/independent party facilitate the board evaluation. The sort of matters the full board evaluation seeks to assess are:

- **understanding and development of strategy** – does the board understand why we are here, where we are going and why?
- **board composition** – does the board have the right skill mix (technical or ‘soft’ skills) for the challenges ahead? Does the board have an adequate level of challenge/dissent to enable respectful but robust discussion (vis a complacent, agreeable board)?
- **access to information** – do directors feel like they get the information they need to make decisions? Are the papers the board gets fit for purpose? Do they understand the entities performance in context? (e.g. do they know is the health service is safe right now – if so, how do they know that?)
- **openness and energy** – this speaks directly to the culture of the board. Do directors feel able to openly challenge one another? How strong is the participation of all directors? Are discussions dominated by one or two directors (or the CEO)? Are directors enthusiastically engaged or are they passive and/or distracted?

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Case Study: Enron

The famous (or perhaps infamous) collapse of Enron should be reflected upon in the context of having several significantly skilled, financial experts on the board.

While there were failings in governance at multiple points, two key elements emerge from any analysis of the Enron board:

- **Lack of openness and energy**
  
  Despite their expertise, the financially skilled directors claimed they found Enron’s financial statements confusing but did not feel safe to speak up or to ‘rock the boat’.
  
  This led to directors being disengaged and often missing meetings or being unprepared.

- **Lack of individual accountability**
  
  The sheer number of financially skilled board members resulted in the other directors deferring to their wisdom rather than ensuring they themselves were confident.
Director self-assessment

The director self-assessment is an opportunity for the individual director to be honest with themselves about the level of input they can, have and should be investing into the entity. Directors should consider if the current level of commitment investment is sufficient and/or sustainable. When considering these questions, the director should focus on the best interests of the entity and an honest assessment of their ability to contribute to the health service. Self-assessment should allow the director to determine if now is the right time to step down or step up.

The sort of matters the individual director self-assessment seeks to assess are:

- **individual commitment** – this is primarily about the use of the director’s time. Is the director’s time utilised in a way that maximises the benefit to the entity; does the director have capacity for the demands placed upon them?

- **use of their knowledge, expertise and experience** – does the director have skills that are critical to the board and are these being used? If not, why not? Does the director understand how their knowledge, expertise and experience should be used on a board (vis using those skills as an employee of the health service)?

- **awareness of current key challenges and personnel** – does the director understand who the current key issues and players are in the organisation? This is a pulse check – if the director is in the past (e.g. I know who used to do that) rather than in the present (e.g. Janet does that) it can indicate the director’s capacity has declined. Can the director describe the key challenges of the health service without deferring to the executive? Can the director describe the current safety issues? Can the director describe the current financial state and challenges? If there was an audit tomorrow, what would be the best matter to look?

- **level of preparation** – does the director read all papers and make enquiries prior to the board meeting? Does the director attend all board and committee meetings? Does the director contribute at board meetings? Is the director consistently on time and on point?

- **Individual accountability** – does the director understand that they are equally accountable for all the work of the board as their peers that may have financial or clinical qualifications? Does the clinician understand he/she has the same obligations and accountability as the accountant on the board (and vice versa)?

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The difficult transition: from expert to leader

Directors are often experts in their field with significant experience and qualifications in their chosen field. This means they have frequently been in a position to give expert advice to help their client make a decision. This advice will frequently be significant for their client such that the expert is accustomed to having to be relied upon – i.e. being right.

As a director, there are two challenges for the expert.

- First, the expert finds themselves on the other side of the advice coin. As a director, their role is to receive advice from their executive and other experts.

- Secondly, the board is a group decision making body. That means the director being ‘right’ or ‘wrong’ isn’t the critical issue – it is decision for the board as a group.

This can be a very difficult transition – from expert (who advises to assist another to make a decision) to leader (takes advice to make decisions) to a director (takes advice to make group decisions).
Peer review

Peer review, where directors review each other’s performance, is one of the most critical elements of board evaluations and is often the part that is missed. In a peer review, each director should review each other director (or at least 3 other directors).

There are many ways a peer review can occur, including using scoring or not. Scoring is useful to assist the group to understand the baseline or ‘average’ director for this board and also what good and bad look like. This enables each individual director to understand what the board as a whole thinks of their performance and contribution. This is of particular importance for the chair in both understanding his/her own performance and not having to be the only source of feedback for a director whose performance is lagging.

The sort of matters peer review seeks to assess are:

- the constructive and less constructive **roles individual directors play** in discussions – does the director play devil’s advocate enough/too much? Can the director change roles when needed? E.g. being the project manager type in one discussion and the cost-cutter in another. Does the director keep the purpose and goal of the entity front of mind?
- the **value and use of directors skills** – does the director have skills and experience that are being used to guide the organisation to be better?
- **interpersonal styles** – Does the director contribute to robust, respectful debate or try to dominate or disappear? Does the director understand the balance between passionate debate and disrespectful argument?
- individuals’ **preparedness and availability** – is this director the one that is often late, looking at their phone in meetings, leaving early, not read their papers, etc. If so, it may indicate that the role on the board isn’t for them – this is not a judgement of willingness or intention, rather an assessment of capacity.
- directors’ **initiative** – does the director think about the health service and the health system outside of the board meeting? Do they keep their finger on the pulse or just turn up to a meeting once a month?
- **links to critical stakeholders** – does the director assist in bringing other views to the table? Does the director understand interests sufficiently to navigate potential conflicts versus an opportunity for the entity?

**What should be assessed?**

Board evaluation and assessment are critical for a board to continue to ensure adequate competency to act in the best interests of the health service, to remain independent and to improve. The purpose of the evaluation is to identify where the board’s strengths and weaknesses are (to enable it to address the weaknesses and exploit the strengths). There is a mix of matters that need to function together for a board to be competent, which should be assessed in any board evaluation.

**Individual directors commitment**

Attendance and preparation for meetings is a proxy for measuring the level of commitment and capacity the director is willing or able to give to the entity. Note that it is not a subjective measure of how much the director would like to dedicate to the board, rather, how much they are able to.

- Attendance of board meetings
- Meeting attendance at committees
- Attendance for other core board functions (e.g. strategic planning day; open access meeting)
- Attendance and participation at ceremonial matters for the health service

Productive meetings / 192
● Being prepared for meetings (i.e. read the papers, raised issues in advance)
● Being on time for meetings.

Board director skills

● The currency of the particular skill/competency they fulfil (e.g. communications, ICT, law)
● Financial literacy – all directors must have a minimum level of financial literacy; they cannot simply rely on the directors with financial qualifications
● Clinical governance literacy – all directors must have a minimum level of clinical governance literacy; they cannot simply rely on the directors with clinical or medical administrative qualifications
● Corporate governance – all directors must understand the core concepts of corporate governance and risk management
● Succession planning for skills that might be leaving the board soon.

Director independence and self-reflection

Director independence serves a critical role in allowing the board to question decisions and improve on the past. This needs to be balanced against the experience, expertise and, in particular, corporate knowledge of the health service that the director has.104

Health service boards in Victoria start with a significant independence advantage that many entities in the private sector do not have, that being the CEO is not allowed to be a director of the board. There are numerous examples of companies that came into harm from the conflict of interest inherent in a CEO as a director model. The OECD has recommended for some time that the CEO should not sit on the board, and if they do, as a minimum, the chair of the board should be completely independent.105

● Tenure on the board – even directors that are strong contributors with highly sought after skills can begin to reduce the effectiveness of the board due to a lack of independence, particularly if that director has to confront the impacts of decisions made under his/her watch
● Interests (conflicted or otherwise) with the health service’s activities
● Connections to staff (or being a former staff member)
● A relationship with the CEO that is too familiar (e.g. friendship rather than a professional relationship that would enable both working with and challenging the CEO)
● Diversity of the board can be a proxy to independence.

While removing a long standing director might be one mechanism of improving independence, director independence and its benefits should not be confused with board renewal. Nevertheless, given one of the greatest predictors of non-independence is board tenure (i.e. how many terms a director has spent on the one board) the board should consider key risks such as business continuity and succession planning when evaluating independence.


Board culture

A board culture that enables directors to feel safe and confident to challenge views, question the executive (and others), and reach a joint decision. Critically, a good board culture will be receptive to ‘bad news’ as a learning experience. It will have the confidence of the CEO, the department and the Minister.

Measuring culture\(^{106}\) of the board should both consider the board’s culture and its ability to positively influence through the health service’s culture through leadership.

“There are two young fish swimming along, and they meet an older fish swimming the other way, who nods at them and says: ‘Morning boys, how’s the water?’ The two young fish swim on for a bit, and then eventually one looks over at the other and goes: ‘What the hell is water?’”...

“The point of the fish story is merely that the most obvious, important realities are often the ones that are hardest to see and talk about.”

- David Foster Wallace, 2005 commencement speech Commencement Speech to Kenyon College. Refer to Useful resources to see the full transcript and YouTube video.

Considerations for evaluating board culture include:

- **Conduct of directors**
- **Ability for directors to hear ‘bad news’ and act on it in a way that enables the organisation to learn**
- **Celebration of any ‘island of integrity’\(^{107}\) or good conduct (e.g. reporting)**
- **Empower senior leaders to own ethical and safe decisions**
- **Risk appetite of directors, in particular, to ensure innovation and learning are embedded and not just an add on**
- **The willingness of directors to question and require adequate information from management and the ability to obtain this – do directors feel like they need to use back doors to get information because the CEO has not provided adequate or timely advice?**
- **Just culture – how do we, as a board, encourage a reporting culture so that people do not feel like it is either a) futile to speak up (i.e. do we value accountability), or b) dangerous to speak up (do we shoot the messenger/complainer rather than learning from the bad news?).\(^{108}\)**

Further information on board evaluation and assessment can be found in *Chapter 5: Board structure and renewal*; and further information on board culture is in *Chapter 11: Organisational culture and leadership*.

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\(^{106}\) EthicalSystems.org have two online (public commons) modules for measuring ethical conduct and a speak up culture. Access the online measurement modules here: [http://ethicalsystems.org/content/ethical-systems-culture-measurement](http://ethicalsystems.org/content/ethical-systems-culture-measurement)

\(^{107}\) Gilman, Stuart C, *Ethics codes and codes of conduct as tools for promoting an ethical and professional public service: Comparative successes and lessons*, (Winter 2005), Washington, p. 75.

\(^{108}\) See the panel discussion from the June 2016 Ethics by Design conference here (full reference details in the useful references at the end of this chapter): [https://www.youtube.com/watch?v=Ap2vRpsJhs&feature=youtu.be](https://www.youtube.com/watch?v=Ap2vRpsJhs&feature=youtu.be)
Useful references

- Tricker, R I (ed), *Corporate Governance*, (2000), Ashgate, Aldershot; Brookfield USA.

Culture and conduct

- EthicalSystems.org have two online (public commons) modules for measuring ethical conduct and a speak up culture. Access the online measurement modules here: http://ethicalsystems.org/content/ethical-systems-culture-measurement

**Board evaluation**


• Governance Evaluator* [http://www.governanceevaluator.com/](http://www.governanceevaluator.com/)

• EthicalSystems.org* have two online (public commons) modules for measuring ethical conduct and a speak up culture. Access the online measurement modules here: [http://ethicalsystems.org/content/ethical-systems-culture-measurement](http://ethicalsystems.org/content/ethical-systems-culture-measurement)


*Note that these sites/providers are not affiliated with DHHS and may be a fee for service online tool. They are included in this resource list as examples of products used by Victorian public health service boards. DHHS does not specifically endorse or guarantee any advice, service or product provided by these providers.*
9. Stakeholder engagement

Effective stakeholder engagement is crucial to meet the evolving needs and expectations of health service consumers, regulators, employees, the Minister and the broader community.

Questions that directors of health services should ask

- Is the board fully aware of its key stakeholders (who it is accountable to) and the reporting requirements?
- Does the board have enough visibility of stakeholder views by using engagement tools such as the patient experience survey and complaints mechanisms?
- How does the board communicate with and hear from its stakeholders?
- Does the board have a good understanding of the objectives and interests of key stakeholders?
- Are stakeholder requirements and stakeholder engagement part of the annual strategy development program?
- Has the board determined stakeholder value and how to measure it?
- Have the risks of not engaging stakeholders (e.g. financial and reputational) been considered, and if applicable, quantified?
- Is stakeholder engagement embedded into the health service’s vision, values and strategic directions?
- Is effective stakeholder management used as a strategic and preventative mechanism, rather than a response tool?
- Is there an anonymous feedback mechanism beyond protected disclosures for stakeholders who frequently interact with the health service?
- Do my stakeholders know why their views are important? Does the board understand why that stakeholder group’s views are important?

Red flags

- The health service maintains no stakeholder mapping, tiering or profiling information.
- Stakeholders are defined narrowly as only the patients and consumers of the health service.
- In most decisions, stakeholders are not considered or consulted or directors think that they represent the community (and thus asking them is community consultation).
- The tone of the Annual General Meetings (AGMs) is tense, confrontational or lacks engagement.
- The risk of not engaging stakeholders is often dismissed by some directors.
- Dialogue with stakeholders mostly occurs in the event of disputes and negative media coverage.
- The health service is unaware or unprepared for the impact of negative feedback on social media.
- All directors are local, narrowing the objectivity and pool of stakeholders engaged.
- The health service does not hold consumer forums, fundraising events or other events that promote the health service within the community.
Introduction to the chapter

Stakeholders form a critical part of any organisation. This is even more so for a health service, where the provision of safe, effective person-centred care relies on the effective interaction of multiple stakeholders.

This chapter looks at:

- what constitutes stakeholder engagement
- how to identify the relevant stakeholders
- why stakeholder engagement, and its timing, is so important
- how to engage stakeholders.

What is stakeholder engagement?

Stakeholder engagement is the process of identifying and involving the key groups of people and organisations who are affected by, or have the capacity to influence, the health service’s activities and operations.

Stakeholder engagement is a critical part of the delivery of safe, effective person-centred care. Listening and responding to the patient voice, ensuring there is an engaged, skilled workforce (including clinical staff), and effective working relationships with regulatory bodies, is all part of the board’s stakeholder engagement activities.

Ordinarily, a board’s direct involvement with its key stakeholder groups may be limited to the board chair or the chairs of committees. In extraordinary circumstances (e.g. crisis mode) the wider board may become involved in the engagement activities and communication.

However, management may often turn to directors to tap into expertise and relationships to facilitate engagement, advocacy and lobbying with key stakeholders. Directors who possess ‘change agent’ competencies can be influential in championing particular courses of action. Although there is no legal standard or equipment for formal stakeholder engagement, most directors now consider their boards could, and should, be much more effective in understanding and overseeing key stakeholder engagement strategies.

Stakeholder engagement is a process of maturity and nuance. This process often starts with identifying who the key stakeholders are. The timing and depth of this engagement can, and should, develop to a point where stakeholders are a critical part of strategy development and continuous improvement within the health service.

![Figure 9-1 Stakeholder engagement maturity model]

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Key stakeholders for health services

Stakeholder engagement for health services goes beyond the patient and beyond the immediate community. Public health services operate in a complex and diverse environment comprising a wide variety of stakeholder groups, including:

- regulators such as AHPRA and the Government (Minister, Secretary)
- monitoring and support entities such as SCV, VAHI and VCC
- medical, nursing, allied health, administrative and support staff
- consumers and suppliers
- other Victorian healthcare providers (community, metropolitan, regional, rural health services)
- consumer advocacy groups
- the media
- business partners such as teaching and research bodies
- professional and industry associations, such as:
  - Victorian Healthcare Association (VHA)
  - Australian Medical Association (AMA)
  - colleges (for example, the Royal Australasian College of Surgeons)
  - unions.

The concerns of these stakeholders are not just financial; they span all aspects of health service provision including operational and quality and safety.

Why focus on engaging stakeholders?

Due to the range of stakeholders that impact health services, effective stakeholder engagement is critical to enable health services to meet their strategic and performance objectives, improve patient safety, and deliver better health outcomes across the public health sector.

Broad and meaningful engagement with consumers, the health service workforce and clinical staff also underpins three of the five elements of the clinical governance framework (as outlined in Chapter 2). Leadership and culture is highly reliant on the outcomes of the stakeholder engagement process to support the high-quality health care outcomes. Embedding these values and behaviours within an organisation requires constant communication and feedback – a key part of stakeholder engagement.

Active and inclusive stakeholder engagement is a key component of planning, development and delivery of services, which impact not only the health service directly, but also the broader community in which health services operate.

Health services that collaborate with and mobilise their stakeholder base are able to present a positive public image and reap the rewards of the reputational and financial benefits that follow.

Managing expectations

Clinical governance has risen to prominence following several incidents that occurred in a context of increasing demand, costs, indemnity pressures and an unprecedented “rise in patients’ willingness and ability to stipulate what they required from the health system”.

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As such, while community needs, expectations and even wishes should be considered by the health service, they must be considered with a clinical governance lens. Put simply, universal access to services has the caveat ‘if safe’. For example, birthing services are often seen as a right for community members. Indeed, an expecting family may believe they have the right to give birth to their new babe wherever they would like. Clinical governance responds to this with: yes, but only if it is safe to do so. If it is not safe given the particular risk profile of that expecting mother, then the health service must refer the patient on to a service that can safely accept the patient. What does this mean for health services? It means that universal access to healthcare has a necessary limitation of reasonable risk and safety. As such, health services are required to manage the community’s expectations as to what the health service can or cannot reasonably and safely do.

In summary, while a critical part of stakeholder engagement is understanding the need of consumers, carers, staff and regulators, managing stakeholder expectations of what the health service can (or should) deliver is also vital. The health service will often have to tell the community and stakeholders what it cannot do, even if that is what the community wants from it.

**Establishing an effective stakeholder engagement framework**

Clearly defined stakeholder engagement arrangements and processes are key to effective stakeholder management. This is achieved through a formally documented stakeholder engagement framework which includes clear stakeholder engagement plans. Common themes of sound stakeholder engagement frameworks include:

- stakeholder maps and tiering
- responsibilities for developing relationships with agreed accountabilities (board and management)
- defined methods for gathering information on/from stakeholders (i.e. surveys, research, etc.)
- methods and accountabilities for monitoring stakeholder concerns, influences and sensitivities
- established positions on relevant public or industry-specific policies
- a variety of methods of communication, including forums, meetings, site visits, etc.

The Victorian *Clinical Governance Framework* (outlined in Chapter 2), provides guidance with respect to effective engagement. Examples of this include listening to the consumer voice as part of the ‘consumer partnerships’ domain, provides critical insight into continuous improvement opportunities for the health service.

**Consumer partnerships – patient specific engagement**

Consumer partnerships are an important area of focus for boards and are also one of the five domains of the clinical governance framework.

When consumer engagement is done well, it builds trust which is critical for enabling the health service to achieve more challenging innovations, such as behavioural change.

One of the board’s main monitoring tools when it comes to patient/consumer feedback is the Patient Experience Survey. The survey is designed to use consumer feedback to support the monitoring function of the board. The Patient Experience Survey is also an important tool for managing risks associated with clinical care services, staff conduct, administrative operations and overall satisfaction levels.

The consumer advisory committee (or equivalent) can be a strong source of intelligence for the board. It can also act as a key group of critical friends to test ideas with. It should not, however, be relied upon on its own (in lieu of actual consultation with the community or patient groups where required).
Behavioural change is one of the most difficult and yet often the most valuable forms of change. Behaviour change emphasises why innovation should not just be a tack on, but it is as important as maintenance. Behaviour change can lead to better outcomes and cost savings simultaneously.

For the board, a key question is how mature the health service is at fully engaging consumers in their processes and decision making. Table 2 below illustrates the evolving maturity of consumer engagement.

<table>
<thead>
<tr>
<th>Consumer participation continuum</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening and understanding</td>
<td>Understanding what is important about water in the lives of different consumer / stakeholder groups.</td>
</tr>
<tr>
<td>Listening and acting</td>
<td>Listening to different consumer/stakeholder groups and acting on what is heard in order to achieve business objectives.</td>
</tr>
<tr>
<td>Engaging and involving</td>
<td>Involvement of consumers or their representatives. Making it easy for them to propose specific ideas or solutions to achieve change.</td>
</tr>
<tr>
<td>Consumer participation</td>
<td>Increasing active consumer participation to bring these ideas to life.</td>
</tr>
</tbody>
</table>

Table 2 Consumer engagement maturity. Source: Adapted from: Corporate Culture Group, TAPPED IN: From passive customer to active participant. (March 2017), Ofwat, UK.

Behaviour change example: Water use in Spain

Problem: Water shortage in Spain, which affects millions of people, is only partly related to rainfall. It is in fact, more the result of a culture of wasting water. In recent years, despite a 10% decrease in rainfall, water consumption has increased by 20%. All of the factors that form this culture reinforce this model of excess water consumption through their reciprocal dependency. This culture of wasting water is seen in industry, agriculture, public mains infrastructure and household usage patterns.

Objective: to reduce household water consumption in Zaragoza by 1,000,000m$^3$ in one year. This was to be achieved by changing consumption patterns and through the effective use of water saving technology.

Actions: Awareness campaign; school outreach program; individuals pledging to reduce; volunteer ‘accomplices’ or champions; free audits of target groups/places that showed both the water reduction and cost savings (of using less water) – this lead to word-of-mouth spread and particular examples going ‘viral’; guidance on ‘how’ the target group reduced water given out so that others could copy and adapt (e.g. a single ‘pledged’ hairdressing salon’s reduced water use and cost savings led to 90% of other salons in the area copying the pledge method to reap the same savings); making water saving devices available for investment.

Outcome: Between 1997 and 2012, per capita use of water in Zaragoza dropped from 150 litres/day to 99 litres/day. The drop even sustained an increase in population; between 1997 and 2008, the city’s population grew by 12% but daily water use dropped by 27%.$^1$
The consumer stakeholder

Consumers generally come to health services due to some sort of issue or distress that needs to be resolved. That means that health services are likely to encounter many vulnerable consumers that have a lower tolerance for system usability issues. For example, a many step, convoluted process may cause a vulnerable consumer to simply abandon their effort to seek help. Alternatively, a process that feels seamless with staff that efficiently and empathetically meet the consumer’s needs is likely to be followed through.¹¹⁰

Some key questions for the board regarding their consumer/patient stakeholders include:

- How do we identify vulnerable consumers to minimise their distress?
- How to we ensure they are supported when they leave us?
- How many times does the consumer have to have the same, potentially stressful, conversation regarding their vulnerable circumstance?

Real case example: Gippsland Regional partnerships

The Gippsland Regional partnership has led to the development of the following:

- Clinical pathways for care across the region for orthopaedics, obstetric, regional BMI and commencement of cardiac pathway.
- Development of a Regional Specialist Workforce plan, with ongoing implementation and joint recruitment of specialists.
- Development of telehealth services for Latrobe Regional Hospital (LRH) and across the region, with LRH supporting small health services with, in particular, after hour emergency presentations.
- Access to specialist clinic appointments via telehealth into LRH and from LRH to Melbourne.

Stakeholder engagement at a board level

Organisations with effective stakeholder engagement possess a common theme of a strong ‘tone at the top’. Boards are responsible for setting the general policies of the organisation. They shape the organisation’s framework for accountability and should lead by example in fostering an outward-looking approach by collaborating with stakeholders, ensuring mutual benefit from business dealings and acting with integrity.

¹¹⁰ The UK Regulators Network (UKRN), Making better use of data: identifying customers in vulnerable situations (A report for water and energy companies), (October 2017), Ofgem and Ofwat, UK.
At board level, stakeholder engagement should be defined as a core organisational value. Directors should identify the key risks associated with evolving societal expectations and set expectations with their executive management group around effectively engaging the stakeholder base. Further, the board should also consider their own interface with stakeholders and integrate stakeholder issues into the board agenda.

**Advantages of effective stakeholder engagement**

Effective stakeholder engagement is a prized asset that requires more than ad hoc consultation with a small group of individuals. Done well, it can be a source of productive and effective working relationships, influencing the level of engagement with the health service by employees, consumers, DHHS and other stakeholders.

By way of contrast, failure to effectively engage with stakeholders can have a negative and prolonged effect on a health service. A disengaged board affects both the health service and directors’ personal reputations, employee morale and overall performance.

Reputational risk has been identified as one of the most important risks an organisation faces. Loss of reputation, however, is usually the result of poor risk management processes across all risk areas, including compliance, finance, clinical considerations and operations. A robust and systematic enterprise-wide risk management strategy is essential to maintain a health service’s reputation.

In turn, a health service’s reputation is directly linked to the board’s role in both strategy and risk. The board’s starting point in developing a positive reputation is the right ‘tone at the top’, fostering appropriate organisational values that drive organisational culture. A reputation management system, underpinned by straightforward and open communications, protects this intangible but vital asset.

Despite the best risk-mitigation program, when things go wrong, a period of personal or organisational reputational volatility can ensue. Reputation is affected by the way an accident/incident is managed or the health service’s ability to react to and handle such a crisis. The health service needs to prepare itself for potential crises. The media is a critical influencer of public opinion, especially in a crisis.

Directors need to know who their stakeholders are, who to engage with and when to engage with them. Investing in getting this right, will result in more tailored and effective outcomes for the health service.
How to obtain stakeholder feedback

Being able to readily hear from stakeholders, whether you are directly consulting with that group on a specific initiative or not, is critical for high performance and delivery of safe, high quality care.

Sources of stakeholder feedback

There are many formal sources of feedback for a health service, including:

- Formal patient surveys (e.g. Victorian Healthcare Experience Survey (VHES))
- Informal patient feedback (e.g. via staff, social media, etc)
- Staff satisfaction surveys (e.g. People matter survey)
- Complaints to the hospital directly or to a third party (e.g. the HCC)
- Community outreach
- Open access meetings where the board opens its meetings to others
- Events and forums inviting particular stakeholders (or open for the community)
- Touring your hospital or participating in a patient experience training (such as sitting in a waiting room)
- Having a patient experience story as a standing item on the board agenda.

The ability for a health service to listen to its staff, patients and guests is particularly important for patient safety and quality of care. This is a significant culture issue, in that staff, patients and guests need to feel not just safe but empowered to speak up when they see something that is of concern. Management and the board similarly need to embrace complaints and criticism as opportunities to learn and/or correct an honest mistake. Mistakes happen, but people need to feel safe to admit to them, speak up when they see them, and take action.

More examples and strategies for developing a just culture are in the Clinical Governance Framework (Chapter 2) and Chapter 11: Organisational culture and leadership.

What should the board seek stakeholder feedback on?

Some questions for stakeholders, such as consumers, staff and the community are:

- What is your view on our priorities?
- What are the key features that made your experience good/bad?
- What would you want in a future health service you co-designed?
- What could we do to help you have more control over your own health and wellbeing?

Example: testing patient experience – the mystery shopper approach

Mystery shopper type testing of the health service to assess how the health service is responding to a particular issue. This can be used to assess many issues for health services including:

- Security – how long was it and how far into the building did the mystery shopper get before they were questioned / challenged adequately to manage a security breach
- Consumer experience – e.g. how long did the mystery shopper have to wait for their appointment? What was the experience like? Was the burden of treatment proposed by the health service proportionate to the burden of disease the test-patient is experiencing?
- Accessibility (disability) – a identify what barriers your service creates for consumers with a disability (for example a simple step could prevent access to a consultancy room)
- Accessibility (CALD) – identify what barriers your service creates for consumers whose first language is not English.
• How could we create a new future together?
• How could we do [service] better?
• What step in the process do you skip (or wish you could skip)? Why?

Tips for understanding your stakeholders:
• Observe, listen, take feedback - appreciate the issues raised.
• Listen first rather than suggesting the solution you want to present.
• Ask your consumers what they think, felt, experienced. Avoid questions that suggest an answer.\textsuperscript{111}
• Help consumers understand why their view is important – what’s in it for them?
• Work with consumers to develop a shared understanding of the future with/without change
• Conversations and consultations will initially start with lots of views – shift this to a real debate based on evidence and informed views to gain deep learning
• Explore your health service. Use the lens of a consumer either by placing yourself in the consumers shoes or engage ‘mystery shoppers’ to test a particular aspect or focus area (e.g. accessibility).
• Test out your change solution on some consumers that are ‘critical friends’, such as your consumer advisory committee, a focus group or through public consultation.

A how example: User acceptance testing

In information technology fields, user acceptance testing (UAT) is a standard and mandatory part of introducing or even tweaking a computer system. User acceptance training acknowledges that there are goals beyond just the technical goals. Technical goals such as data integrity, security, speed and cost are of course important, but they are all for nothing if users refuse to interact with the system due to it being ‘unusable’.

UAT acknowledges that there are different types of users of a system, ranging from:

\textbf{Super or savvy users} – users who have to use the system regardless of its usability. Their frequency of use means they learn to navigate it regardless of how poor the system is. through to

\textbf{Vulnerable or discretionary users} – characterised by users that you want to use the system. These users may see your system as a barrier they don’t want to engage with before even trying to

\textsuperscript{111} Dragt, Els, \textit{Be an explorer to know your customers}, (May 2017), Design thinkers academy, London.
engage with it. These users do not have the repetition experience or necessity of use that the super-users have and as such will rely on the intuitiveness and usability of the system. This means that if your system is not usable or intuitive, these users take up a disproportionate amount of your time in support and become intolerant of usability issues quickly.

The board may only need to understand one subgroup or all depending on the circumstances. Regardless, the health service must consider there are always different types of users impacted by any change.

Values based health care case study: the “war room”.

The “War Room” is all about transforming our service to move from volume to value – improving health outcomes that matter to the people we care for.

Transitioning to values based healthcare - How was this done?

At Dental Health Services Victoria, we realised that we could no longer do things the way they have always been done. We needed a new system that could meet 21st century needs and expectations.

While we were meeting our targets, our staff members were disillusioned by the lack of impact we were making and our patients wanted and expected more. Inspired by the global move towards value-based healthcare, we started our mission to transform oral healthcare in Victoria.

An essential component in our transformation was ensuring we co-designed the system with consumers and had employees with diverse expertise collaborating on the project. We created a physical space – our value-based healthcare ‘war room’ – where people could come together to research, debate, hypothesise, plan and evaluate.

What is our current state?

We started analysing our current system focusing on our general and emergency models of care. We mapped out the patient journey and invited staff members to challenge each step. We started by getting together a group of staff who are engaged in delivering consumer facing client contact, administration and clinical services at the various stages of the client journey. Using the largest wall in the room they mapped the current state underlying processes of the high level consumer journey.

As part of the mapping process they identified:

- opportunities (there were a lot) where process waste and other pain points interrupt the flow of value to the client and don’t deliver the desired experience for both clients and staff;
- areas that required a ‘deeper dive’ exploration to help us understand what was happening.

More people (staff and consumers) have entered the ‘war room’ and contributed to the process. This helped us identify that there were multiple patient experiences and several flaws in the system. For example, a decommissioned form was being used in several different ways throughout the organisation.

Next step: consumer consultation

Our next step was to consult with consumers. So, concurrently with mapping our current state, we also facilitated (using an appreciative inquiry approach) a series of voice of the consumer focus groups with current and potential users of our services and staff.

Through these groups we were able to gain insight into:
• what consumers valued from oral health services; how services compare to the consumer’s expectations about the things they valued; and what oral health services can do differently to improve oral health outcomes and experiences.

• the current state experiences of the clinical and non-clinical workforce; what they highly value and what would make things better for them.

With their new holistic understanding of the current state of the consumer journey, and informed by the voice of the consumer about the things that matter most to clients and staff, the mapping team designed the ideal state (which could be achieved in an environment without constraint). With this end in mind, the team then developed a future state which moved us from the current state in the direction of the ideal state, but which could be achieved (with a little ‘stretch’) within 18 months to 2 years.

We then asked our staff and consumers to dream up their ideal patient journey, completely unconstrained. Once their ideal scenario had been documented, we considered the barriers and designed a realistic future state.

Through this process, we:

• removed several steps from the patient journey
• identified limiting policies and procedures
• redesigned clinical pathways with a focus on safety and quality
• identified clinical variations
• identified services that don’t improve health outcomes and committed to stop providing them
• began finalising health outcome indicators
• started relocating tasks to ensure all members of the dental team work to their full scope of practice

• analysed the location of services and where they should be moved to.

This change project has been underpinned by our strategic plan that focuses on improving health outcomes, improving the experience and being a great place to work and a great organisation to work with.

Key learnings from this process?

A strong focus and commitment to cultural change has been essential. We have supported our staff to feel comfortable about new ideas and changing practices while empowering them to challenge the status quo and stand up for safety.

In addition to our strategic plan, the domains from the Clinical Governance Framework have channelled our focus:

• Leadership and culture
• Consumer partnerships
• Workforce
• Risk Management
• Clinical practice.

Guided by these focus areas, our touchstone question is:

Have we improved the health outcomes that matter to our patients and minimised the cost to achieve that health outcome?

All of us lead the change with that question in the forefront of our minds. Our consumers keep us accountable and honest. The Board listens to reports on the journey and supports the organisation to maintain focus, accepting that change will not happen overnight.

We recognise that we won’t always get it right. When we don’t, we will evaluate and redirect our focus. By trusting each other, trusting the process and understanding the ‘big picture’, we know we will be able to improve health outcomes for the benefit of the community.
Social media

Social media provides unique opportunities to engage with users and other stakeholders on a personal level. It can be a very powerful tool to get feedback on early ideas, concepts and prototypes for digital services and can support decision making and policy development. It’s also a service delivery channel to provide assistance, inform people of services available and make announcements.

It takes a substantial amount of time and money to create quality social media content and generate and maintain a social media following. Often, it can be more effective to use existing channels, such as email or traditional communications mediums.

A ‘how to’ guide for social media, including guidance on accessibility, managing public records (all published material from a public sector organisation is a public record), privacy, consulting online, checklists and templates are available from www.vic.gov.au.\(^\text{112}\)

Social media guidelines

Social media policies need to include the general responsibilities as a public sector employee under the Code of Conduct for Victorian Public Sector Employees (VPS Code of Conduct). This policy is based on sections:

- 2.2 Remaining apolitical
- 3.2 Using powers at work
- 3.4 Official Information
- 3.5 Public comment
- 3.9 Public trust
- 5.3 Work resources
- 5.4 Open to scrutiny
- 6.1 Fair and objective treatment
- 6.2 Privacy and confidentiality
- 6.3 Maintaining confidentiality
- 6.4 Equity and diversity

The Useful Resources section at the end of this chapter has a number of social media references and tools for health services to consider.

Types of social media

There are a broad range of social media platforms and services that can be utilised by the health service. A sample of some of the main services is below (collated by vic.gov.au).\(^\text{113}\)

Twitter

Twitter is a free social networking and micro-blogging service that enables its users to send and read messages known as tweets.

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113 Go to https://www.vic.gov.au/social-media.html for examples
Facebook
A social networking website where users can add friends and send messages, and update their personal profiles to notify friends about themselves.

Mobile Apps
These downloadable apps provide a wide range of specific functionality for Android, iPhone, Blackberry and many others. To see a selection of available apps from the Victorian government, go to https://www.vic.gov.au/social-media/mobile-apps.html

Widgets
Widgets is a free social networking and micro-blogging service that enables its users to send and read messages known as tweets.

Flickr
Flickr is an online photo management and sharing application.

RSS
This is a family of web feed formats used to publish frequently updated works such as blog entries, news headlines, audio, and video in a standardized format.

Podcasts
A podcast is a programme (usually audio, sometimes video) which is made available as a downloadable digital file... - wikipedia.

YouTube
YouTube provides a forum for people to connect, inform, and inspire others across the globe and acts as a distribution platform for original content creators and advertisers large and small.
Video

Video is published over the Web in a variety of ways throughout many different sites. Some stream through your web-browser while others are downloadable.

Blogs

A blog is a personal journal published on the Web consisting of discrete entries (“posts”) typically displayed in reverse chronological order so the most recent post appears first.

Google+

A multilingual social networking and identity service. Google calls it a “social layer” which is not just a destination site, but rather something that Google has added as a layer across many of its properties.

Pinterest

Pinterest lets you organize and share all the beautiful things you find on the web. People use pinboards to plan their weddings, decorate their homes, and organize their favorite recipes.

Instagram

Instagram is a photo-sharing service that enables users to take pictures, apply filters to them, and share them on Facebook or Twitter. Instagram’s distinctive feature confines photos to a square shape, similar to Polaroid images.

LinkedIn

LinkedIn is a social networking website for people in professional occupations. Users maintain a list of contact details of people with whom they have some level of relationship. Users can create a profile in order to showcase work and experiences, and help them discover new people.

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Figure 9-2 Social Media Comparison Infographic (August 2017). Source: Leverage New Age Media, https://leveragenewagemedia.com/blog/social-media-infographic/
Useful references

Stakeholder engagement tools and guides

- Patient Experience Survey.
  - For results, go to: https://results.vhes.com.au/

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Social media

- Helpful Technology has a collection of techniques, strategies and examples that are continuously updated under public commons licence on their website - The Digital Engagement Guide: Ideas and practical help to use digital and social media in the public sector. Visit the site here: [https://www.digitalengagement.info/](https://www.digitalengagement.info/)

• Stuart, B and Berry, A, *Creating a social media policy for your not-for-profit*, (Creative Commons license 2018), Connecting Up. Available here: [https://www.connectingup.org/learn/articles/creating-social-media-policy-your-not-profit](https://www.connectingup.org/learn/articles/creating-social-media-policy-your-not-profit)


**Stakeholder engagement examples**


• Helpful Technology has a collection of techniques, strategies and examples that are continuously updated under public commons licence on their website - *The Digital Engagement Guide: Ideas and practical help to use digital and social media in the public sector*. Visit the site here: [https://www.digitalengagement.info/](https://www.digitalengagement.info/)


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10. The CEO

Board and management play two distinct but equally important roles – the board sets the vision and strategy and the CEO handles implementation and operation.

As the group responsible for the appointment, performance management and removal of the CEO, the board must be clear on the difference between the two roles and select candidates accordingly. The CEO is the link between the board’s strategy and its implementation having responsibility for the day-to-day operations of the organisation.

Questions that directors of health services should ask

- Does the board have confidence in the CEO and the senior management team?
- Does the CEO understand the role (including the obligations and monitoring requirements) of the board?
- Does the CEO, through attitude and behaviour, reinforce the appropriate ‘tone at the top’ for all employees of the health service?
- Does the board have a robust CEO selection process in place that aligns with the VPSC and relevant Enabling Act?
- Prior to the appointment of a new CEO, do we (through the chair or nominations committee) conduct rigorous reference checks?
- Is the CEO’s view regarding senior management and other talented people with strong leadership qualities considered?
- Have we developed a CEO and senior management succession and contingency plan that is periodically reviewed?
- Do the CEO’s responsibilities include attracting, developing and retaining high performers in the organisation and does the CEO encourage these activities?
- Are concerns about the CEO’s performance discussed with the CEO and appropriately documented?
- Does the board have a transparent process for determining management and executive remuneration?
- Does the board obtain Secretary approval prior to a CEO appointment or reappointment?
- Does our CEO take our concerns and/or directions seriously?

Red flags

- The CEO selection process is conducted largely in-house within a pool of board directors’ friends and business associates.
- The CEO has been in the role for more than ten years without the market being tested.
- The board simply ‘ticks the box’ for CEO recommendations.
- Support and confidence in the CEO is divided amongst board directors.
- The CEO does not have KPIs or they are often not being met.
- CEO performance appraisal is conducted infrequently and informally.
• No contingency plan or succession plan exists for the current leadership structure.
• The CEO seems focused mostly on achieving their own remuneration targets.
• The CEO treats the board as an obstacle or burden, rather than with appropriate respect and due diligence.
• There is no senior executive development plan in place.
• There is no regular review or external assessment of senior executive talent.
• The board has restricted or no access to senior management.
• The CEO is regularly at entire board meetings (i.e. there are no in-camera sessions).

Introduction to the chapter

This chapter considers the following:
• the relationship between the CEO and the board, and the separation between governance and operations
• how to set the board and the CEO up for success
• CEO succession and contingency planning.

CEO and executive management

The CEO wields considerable delegated authority, reinforces the ‘tone’ of the health service and represents the organisation to external parties.

It is usual practice for a CEO to establish an executive management team (or similar) to:
• support the CEO
• exchange information and ideas
• provide input on the organisation’s direction
• influence the organisation at all levels.

Building a strong executive management team is essential for organisational success, especially at the more complex health services.¹¹⁴

Factors associated with strong organisational leadership include:
• respective board and management roles and responsibilities are clearly delineated and articulated in writing
• board protocols covering directors’ access to executive managers outside of board meetings
• a CEO that provides appropriate direction, mentoring, support and guidance to executive management
• executive management who are empowered to share leadership responsibilities
• executive management who are rewarded for organisational, unit and individual performance,

¹¹⁴ The number and type of members of the executive team is health service specific. Some smaller services may only require the CEO and one other executive.
Even though a board delegates its authority to the CEO it cannot delegate its accountability.

Role of the CEO

It goes without saying that, as a health service’s most senior officer, the CEO is critical to the performance of the service. The scope of activities and responsibilities assigned to the CEO are broad and far-reaching. Through their attitudes and behaviours, CEOs are instrumental in reinforcing the ‘tone’ of the organisation.

An effective CEO of a Victorian public health service:

- passionately leads and develops people
- is wise, courageous and makes the tough decisions
- always acts with integrity
- drives strategic vision and innovation
- is resilient in the face of setbacks
- successfully adapts to the health service’s ever-changing circumstances
- demonstrates high-level commercial acumen
- meets immediate performance targets without neglecting longer-term growth opportunities
- provides visible leadership and commitment to the provision of safe, quality healthcare
- actively supports and demonstrates the expected conduct and culture of the service as set by the board.

Delegated authority, not accountability

In putting its relationship with the CEO on a sound footing, a board needs to formulate a CEO’s job description and define the criteria for the CEO’s performance (usually led by the chair). There should also be a formal statement delineating the boundaries between board and management responsibilities, including the board’s retained authorities and those delegated to management (which is usually set out in the board charter/by-laws). A high-performing board will invest time and effort in constructing a synergistic partnership with the CEO and executive management. It will not be a relationship based mainly on supervision, but one in which the board engages with the CEO and executive management to achieve outstanding results.
The CEO performance appraisal is an important board responsibility and should take place on an annual basis. Further, the appraisal should reflect the priorities in the SoP (or other agreement with DHHS). This appraisal provides:

- important feedback to the CEO about their performance
- increased understanding of the CEO’s concerns and views on the achievement of corporate objectives
- a forum to build a healthy relationship between the board, especially the chair and the CEO
- a framework for the CEO to further develop capabilities
- a forum to reinforce accountability, transparency and the responsibilities of the CEO
- an opportunity to identify and address early warning signs of possible difficulties
- an opportunity to discuss any future plans the CEO may have (e.g. retirement)
- ability to meet requirements of the Enabling Act.

A robust appraisal process should be established that reflects the health service’s unique circumstances. This work is generally the responsibility of the CEO appointment committee, which will make recommendations to the entire board.

A more accurate picture of CEO performance can be gained by incorporating the views of several groups. For example, directors, executive management, DHHS, customers, suppliers and other key stakeholders will all have a view on the CEO’s performance. This must be handled sensitively and all comments treated confidentially to uphold the integrity of the appraisal process.

Both quantitative and qualitative indicators may be included to assess the CEO’s leadership behaviour and performance goals. Using only financial, operational and clinical performance measures is inherently problematic.

There are an array of factors outside the direct control of the CEO that can affect organisational performance. A CEO may be performing strongly when the health service is not and vice versa. Also, stakeholder value can be measured from a number of perspectives, with startlingly different end results. In any event, CEO performance should be measured not only against short-term financial performance, but also on the CEO’s own performance, especially against agreed key performance indicators and strategic objectives.

Professional development and support

A key element of attracting and retaining a good CEO is the provision of a professional development plan and other supports. Formal professional development, training and memberships/professional affiliations are often included as part of the CEO’s total remuneration package (TRP). Regardless, the board should consider not just how the CEO is performing but what supports could/should be in place to obtain the best performance from the CEO. Many supports are available without formalised costs (such as peer networks) others will have a time and financial cost (such as a course).

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115 The HLA Bill requires formal annual performance assessment of the CEO by the board in line with the KPIs in the SoP. Refer to HSA (post HLA Bill proclamation) sections 33(2), 65S(2) and 115E(2); ASA section 18(1); MHA section 332A.
Example: Growing the pipeline

Kala manages a busy inpatient clinical service team and reports to the Lachlan, the Director of Medical Services (DMS) at Better Care Services. She took on the role initially when the then unit-head departed suddenly. Kala had expressed some reservations about taking the role but her manager at the time saw great potential in Kala’s “soft skills” – the sort of skills that aren’t part of her qualifications, rather they are the skills that enabled Kala to bring the team out of a morale malaise. With Lachlan’s encouragement, Kala got the role.

Kala’s new supervisor, Rachel, is the DMS. Rachel, thinks Kala could take the step into an executive role but she has no executive experience and is unsure whether Kala could shift her perspective from the minutiae of each day to the broader, more strategic role. Kala had acted in the DMS role a couple times when Rachel went on holiday and by all accounts was very strong. That opportunity only comes once per year and Rachel is very aware that Kala would likely not benefit from yet another short stint as much as others in the BCS who have never had the chance to have a short, supported acting sting.

Rachel approaches the CEO at Patient Centred Hospital (PCH) due to knowing that the PCH DMS is about to go on maternity leave. The CEO complains about how hard it is to find good clinical leaders in rural areas and asks Rachel if she knows of anyone in her networks that could take on an acting-DMS role. The role would be just under a year and supported by a good team with strong managers. This is exactly the sort of opportunity Rachel was looking for and so she suggests Kala.

The acting DMS role at PCH will build Kala’s confidence as well as her strategy and leadership skills. It is a longer period of time than just a holiday, yet, it is within a space where the rest of the DMS’s team are still on board and so Kala will be supported with a full team.

The CEO at PCH and Rachel agree to offer the role to Kala, with a mentor from ACHSM to help her with some of the administrative aspects. Rachel also agrees to remain a key support and sounding board during the secondment. This secondment will both help Kala’s career mobility, but also the Victorian health system by rounding out Kala’s experiences and helping to develop a strong leader.

This example required:

- Kala be identified as emerging talent (both by Lachlan and later by Rachel)
- Kala’s experience/skill gaps be understood
- A leader willing to take a risk (both Rachel in supporting Kala at the risk of losing her to PCH, and the PCH CEO for taking on someone that will need transitional support)

How Kala performs will be a significant learning experience for all parties to inform future professional development and support offered to Kala and succession planning both for BCS and the region.
Supports that the board should consider for the CEO and executive team include:

- Mentor\textsuperscript{116} and/or coach
- Professional affiliation with member based organisations that enable access to professional development to maintain technical skills
- Membership with a peak body for executives, for example the Australasian College of Health Service Management (ACHSM), to provide access to professional development and supports for health CEOs and executives
- Networks across the primary expertise/discipline to enable best practice knowledge sharing (e.g. if the executive has a law background, membership with the Law Institute of Victoria may assist the executive in maintaining the currency of their skills)
- Networks to key organisations with relationships with the health service (for example, the PHN in the catchment area)
- Health and wellbeing supports (such as mindfulness training, mediation, personal support networks, fitness)
- A professional development plan that includes regular opportunities to attend learning and networking opportunities.

The above supports are also critical for emerging talent as it is identified to allow the health service to support the transition to leadership.

**CEO succession planning**

The purpose of succession planning is to ensure the board always has available a number of successor candidates in the event that the incumbent CEO departs suddenly and unexpectedly. Ideally, succession planning should start from day one of a new CEO’s appointment.

Managing CEO departures – whether due to tenure being reached or underperformance – can take time. It is important to be aware of the time involved and to ensure that there is a succession plan and appointment process running parallel to the exit plan.

In some cases, CEOs do underperform. When this happens, it is the board’s responsibility to manage the transitional arrangements. When done well, this process can be done with professionalism, respect and minimal disruption to the organisation’s operations.

The needs of health services are unique and often change over time, as does the available pool of talent from which a new CEO may be drawn. The board should ask the CEO to provide an assessment of the key internal contenders and what is being done to develop their strengths and overcome any limitations.

Some organisations approach succession planning by considering different contingencies, ranging from crisis management (e.g. if something untoward were happen to the CEO, could the organisation continue to operate successfully?) to long-term issues (e.g. are we attracting, developing and retaining individuals to be future leaders in 3 to 5 years?).

At the heart of CEO succession planning is the notion that the board and the CEO work in cooperation to attract, develop and retain high performers who can be tried and tested prior to possibly being offered the CEO role in the future.

\textsuperscript{116} See, for e.g., Australasian College of Health Service Management (ACHSM), *Mentor Guide* (2018).
CEO tenure

In the lead up to the expiry of a CEO’s contract, the CEO must undergo a performance assessment prior to any recommendation to re-appoint (which must then be approved by the Secretary). If the contract expiry is approaching (or past) the CEO’s tenth year, it is DHHS policy that the board must re-test the market and seek applications for the CEO role. The current CEO can still be reappointed if, upon testing the market, they are considered by the board to be the strongest candidate. If the board seeks reappointment of the current CEO, reasons must be provided to the Secretary.

Only the Secretary can approve the appointment or reappointment of a CEO.

The issue of tenure is not simply about renewal. It is about the independence of the executive from the board and ensuring the board maintains a clear vision for the future of the organisation it oversees. Recruitment of the CEO requires honesty, openness and transparency to ensure integrity in the recruitment process. By ensuring an open, merit-based process has been followed, without bias or impartiality, you promote public confidence in the decision-making of your board.

As boards are required to ensure that the health service performance meets the objectives of the Enabling Act, the appointment, retention and replacement of CEOs is an important board function. Boards must be prepared to replace a CEO if they consider that they are not performing, or believe that future performance may not be up to the level expected or in the best interest of the strategic goals of the health service.

Investment in the CEO and management team is crucial for the creation of sustained value. For this reason, directors need to commit considerable time and effort to CEO selection. This should be supplemented by appropriate mentoring, development, encouragement and support; a role often fulfilled by the chair.

When CEO performance concerns arise, these should be formally discussed and addressed promptly. If it is clear that the CEO is not delivering and needs to be replaced, then the board should act without
No board director will be considered for a CEO position of their health service due to the inherent conflict of interest that this creates.

CEO appointments and reappointments (contract renewals)

The Enabling Act requires that the board appoints the CEO and determines their remuneration subject to the approval of the Secretary. The selection of a CEO is one of the most important tasks a board can undertake. It is also probably the most difficult. Boards should drive the succession process, although normally in collaboration with the incumbent CEO. Boards sometimes select a CEO heir-apparent well in advance of the incumbent CEO’s planned departure.

For health services with good succession planning, the selection of a CEO may appear almost automatic with a suitable successor long identified. However, as executives become more mobile and the typical CEO’s job tenure continues to shrink, conventional succession planning may not identify an unequivocally acceptable internal candidate.

Similarly, for many health services in regional and remote areas, identifying appropriately skilled CEOs can be particularly challenging. Many boards will need to look not just beyond the health service’s own executive ranks, but much further afield, if they are to find the best available CEO.

The board must ensure that robust processes are adhered to in the lead-up to the appointment. Experience suggests that the probability of a successful outcome is enhanced if boards follow a structured appointment process.

Confidentiality is critical throughout the appointment process. Any breach will deter potential candidates and reflect poorly on directors and the organisation as a whole.

The VPSC provides guidance with respect to the appointment processes in place for public sector entities. At a high level, the steps involve:

<table>
<thead>
<tr>
<th>Prepare</th>
<th>Attract</th>
<th>Select</th>
<th>Implement</th>
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</thead>
<tbody>
<tr>
<td>• Establish a recruitment sub-committee</td>
<td>• Create Position Description</td>
<td>• Rank candidates</td>
<td>• Communicate the decision to the entity</td>
</tr>
<tr>
<td>• Develop the brief</td>
<td>• Create marketing/promotional material</td>
<td>• Approve the candidate ranking</td>
<td>• Ensure transitional plans are developed and in place to assist with the change in CEO.</td>
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<tr>
<td>• Check the legislation</td>
<td>• Collect and review candidate submissions/CVs</td>
<td>• Make an offer</td>
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<td>• Develop project plan and contingencies</td>
<td>• Create and review the short list</td>
<td>• Negotiate terms</td>
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<tr>
<td>• Define employment terms and conditions</td>
<td>• Communicate with short-listed and non-short-listed candidates</td>
<td>• Obtain Department Secretary approval prior to signing any contract</td>
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<tr>
<td>• Engage an executive search consultant (optional)</td>
<td>• Undertake interviews</td>
<td>• Document the recruitment process and decisions</td>
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<td>• Establish a selection panel</td>
<td>• Perform final checks</td>
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<td>• Approve the preparations with DHHS</td>
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**Figure 10-2 CEO Appointment process (Source: VPSC)**

Contracts should not be signed in advance of receiving Secretary approval.
The VPSC has developed the ‘Recruiting a CEO’ guidance document to assist boards with this process. The guidance includes useful tools and templates, including:

- CEO recruitment brief template
- guidance with respect to ‘Considering Candidates’
- notes on ‘Setting the CEO up for success’
- best practice recruitment toolkit (2008)
- executive and remuneration guidelines and resources.

Refer to the VPSC website118 for more information noting it is broad guide and there are additional requirements to comply with under the Enabling Act.

The party, terms, conditions and remuneration for all CEO appointments, reappointments, contract variations and renewals require the Secretary’s approval.

Executive remuneration policy

Pursuant to the Enabling Acts, the boards of all health services, VIFMH and AV are responsible for appointing the CEO and determining, subject to the Secretary’s approval, the remuneration and terms and conditions of appointment.

The salary and terms of appointment for the CEO and other executives must be consistent with the Government’s executive employment and remuneration policy. Executive remuneration and employment policy for Victorian public entities, including health services, is managed by the Government Sector Executive Remuneration Panel (GSERP). The VPSC provides advice and support to GSERP, which is appointed by the Premier.

The policy on executive remuneration for public entities in the broader public sector explains how remuneration is determined and approval procedures. Boards are responsible for ensuring their health service adheres to the policy and the approval and reporting requirements. It is recommended that boards and CEOs read the policy, which can be found at <www.vpsc.vic.gov.au>.

The policy requires remuneration packages for all CEOs to be endorsed by the GSERP. The GSERP’s endorsement must also be sought for other executive packages if the remuneration and terms proposed fall outside guideline rates and policy parameters.

Under the policy, boards are required to establish a remuneration subcommittee with specific responsibility for determining the organisation’s policy and practice for executive remuneration and the individual remuneration packages for its executives. The policy also requires information on executive remuneration to be disclosed in two ways:

- in the annual report as required by the FMA and any Standing Directions issued under the FMA
- in a remuneration committee report to the GSERP that sets out the organisation’s policy on executive remuneration, including details of total remuneration packages for individual executives, comparator organisations, and a statement about compliance with Victorian Government policy parameters.

The policy provides the Victorian Government with a tool to ensure executive remuneration is not excessive and, where increases are appropriate, that they are broadly in line with wage movements in the general community, particularly with public sector levels. The purpose of the policy is to ensure accountability to the Victorian Government and community by disclosing information on executive remuneration policy and practices through the annual remuneration committee reports to the panel and in annual reports.

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Useful references

Leadership and culture underpin the success of the health service. In a time of increasing complexity and significant growth in the expectations, responsibilities and risks that health service face, advanced capabilities and complex skills are required from directors. A director’s leadership and stewardship is critical to the safety and quality of healthcare for all Victorians.

Questions that directors of health services should ask

- What sort of culture is the board creating and demonstrating to its staff?
- What sort of culture exists within the health service?
- How accessible and visible are we as directors?
- How clear are our values? How clear is our purpose (the why we exist which underpins our values)? What are our guiding principles (i.e. what helps us make decisions)?
- Do staff and consumers feel free to ‘speak up’ when they see something awry?
- Has an organisational culture been developed and maintained that creates an environment of openness, honesty and encourages the immediate reporting of bad news?
- How do we deal with bad news? Do we try to hide it, or do we welcome the feedback as an improvement opportunity? Do we celebrate feedback or dismiss it?
- Has the board considered how executive compensation aligns with the desired ethics and compliance culture?
- Does every staff member (clinical, non-clinical and volunteers) understand the important role they play in achieving our strategy?
- Do the health service’s internal and external auditors report that the culture is open and honest?
- Have any compliance investigations arisen from a cultural problem?

Red flags

- The board has power factions that inhibit teamwork.
- Lack of director commitment and/or capacity e.g. poor attendance at board meetings and other major events of the health service.
- The board suffers from a ‘group think’ mentality.
- A director has a clear agenda, bias or ‘bug-bear’ that they focus on rather than the issues.
- The board culture does not allow discussion of difficult, controversial or sensitive matters in the boardroom.
- There are regular and/or entrenched conflicts between leadership and the board leading to lack of direction for staff.

The Institute of Internal Auditors Australia, The Ethics Centre, Chartered Accountants Australia & New Zealand, Governance Institute of Australia, Managing Culture: a good practice guide, (December 2015).
• Clinical leaders are disconnected from the organisation’s clinical governance processes and systems.
• People are afraid to raise concerns or report issues for fear of nothing happening, or for fear of being reprimanded.
• Staff engagement and satisfaction is not measured and is not a priority area of focus for the board.
• There are ongoing problems with staff turnover and complaints and/or high levels of sick leave.
• The CEO (or a specific executive) is the only executive the board ever hears from, with others not permitted to appear or present to the board.
• Directors by-pass the chair and question health service staff without the CEO or chair knowing.
• Poor patient experience indicators (e.g. rising complaints)

Introduction to the chapter

The importance of culture in a health service and the board’s role in ensuring a ‘just’ culture exists is critical. Whilst culture is embodied throughout an organisation, the board is responsible for setting the expectation and ensuring that behaviours and values are lived. This chapter looks at:

• the importance of establishing a good culture
• identifying and addressing cultural issues
• managing culture in the boardroom.

The tone at the top

The ‘tone at the top’ refers to the character and behaviour displayed by leaders of an organisation that forms a model of appropriate conduct for every level of the health service. Boards bear ultimate responsibility for their organisation’s culture, including:

• not just ‘what’ the values and practices of the organisation are, but ‘how’ the policies and processes are put into practice
• development and implementation of accountability mechanisms
• defining the ethical environment that underpins that culture
• ensuring a ‘just’ culture for the provision of safe, quality care.

As stewards of the organisation, boards must embed the ethical and behavioural culture into an organisation. Merely meeting legal requirements is not sufficient to satisfy the ethical concerns of the Minister, DHHS, employees, consumers, the community and other stakeholders.

Whilst there are legal obligations and guidelines to support an effective ethics and compliance culture, the culture of an organisation cannot be dictated by rules and regulations alone. Culture is about behaviour and behaviour cannot be regulated. It is therefore the role of the board to ‘set the tone’ with respect to the types of behaviours it expects and accepts.

Boards set the ‘tone at the top’, which influences the entire organisation.

The board should ensure appropriate values, ethics and behaviours are upheld throughout the organisation. This means that the board and directors must:

What is a safety culture?

A safety culture refers to a culture whereby health service staff are supported and their wellbeing prioritised. It includes:

• A just culture (balancing a no-blame approach with accountability)
• Providing staff with training and development opportunities
• ensuring the health and safety of their workplace – including mental wellbeing

In practice this involves giving staff the right opportunities to provide feedback about their workplace or colleagues regardless of their position – and to expect that a fair and transparent process is in place to address any issues in a proportionate and sensitive way.
It is the board’s responsibility to ensure that every person in the organisation acts appropriately regardless of their position.

Structural risks to culture

Health services are large, complex entities. Even the small rural health services have multi-million dollar budgets and are one of the community’s largest employers. This, plus the range of regulatory regimes and other controls, necessitates structures that are typically hierarchical in nature. This allows for clear lines of accountability, responsibility and supervision of staff.

The higher up in the hierarchy, the less detail is known but the greater overview. In contrast, front line staff will be primarily absorbed in the day-to-day of caring for patients and leave the running of the larger entity to those further up the chain. This is the idea of the view of a forest (the board’s view); the trees (executive and management) and the leaves (units, teams and front line staff). In this analogy, the board is looking at the forest from above; they won’t generally notice a leaf on its own change but should if it starts to spread. Ideally, there are controls to prevent the infection but should one occur, before the issue spreads, it is noticed by management or the executive and acted upon.

This is a common description of hierarchical structures that are important for accountability. However, the risk of simplifying people’s roles like this, is that it can miss the critical role staff play in fulfilling the purpose and strategic objectives of the health service, and vice versa, the role that leaders play in enabling patient experience and quality of services on the ‘front line’.

Command and control is the hierarchical compliance based culture present in most large entities, including public entities like health services. It relies on rules with penalties if rules are broken and sometimes rewards to incentivise certain behaviour. The idea being that people’s self-interest to avoid a penalty will prevent them from being tempted to take advantage of a forbidden benefit. While a rules (with rewards and punishments) based approach will always have a place it has the potential to 

“invite misconduct where its reward is significant and either the risk of detection, or the punishment if caught, is perceived as acceptably low”.  

In this setting, the presence of incentives could also undermine the desired culture, if the incentive to reach a goal outweighs the risk to the individual (or entity) of how that goal is achieved. For example, improving performance on length of stay KPIs could increase the chance of early discharge. As such, while incentives or punishments have a place for reaching targets and compliance, they cannot be relied upon in isolation and can indeed undermine your cultural goals.

Ultimately, a culture that is informed by notions of ‘integrity, fairness, respect and dignity”  

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121 Ibid.
effective at driving compliance with the actual goal of the rule, rather than crudely adhering to a rule as much as one has to.

There is a place for compliance with rules and working to achieve metrics, however, if decisions to comply are based solely on self-interest and not a greater principle or values proposition, then corruption is likely wherever the reward outweighs the risk.

To reduce the risks inherent in the command and control approach, the board must take a values based approach to the health service culture.

**Why ethical people make unethical choices**

Carucci summarised the top reasons people make unethical choices as follows:122

1. **It is unsafe to speak up**

This could be from two main sources:

- the sense of futility (nothing will come of my report)
- fear of retribution

How the supervisor or management react to people reporting misconduct or other issues is the greatest factor – do management welcome and celebrate the report (see example on the right)? Or do they try to minimise it or treat it as a burden?

2. **Performance targets prioritised above all**

While performance targets have a clear place in health services, the targets should not be such that they incentivise cutting corners, particularly if that increases the risk of error.

3. **Conflicting messages that feel unfair**

Where leadership have one message in words but another in their actions can quickly lead to a sense of injustice.

4. **Insufficient positive role-models**

The leaders of the organisation should set the tone and standard of conduct expected. This includes being a supervisor of a team all the way up to the CEO and the board.

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122 Carucci, Ron, Why Ethical People Make Unethical Choices, (December 2016), Harvard Business Review.
Values based frames of reference ask ‘how do you behave when no one is looking?’

In particular, the health service senior leaders, including the executive and the board, should demonstrate a high standard in their decision making.

Ethical based frameworks

This leads to what might appear to be a cultural conundrum: blame versus accountability. Many would regard accountability as being the person to blame for something going wrong. In a completely self-interested world, that is more or less true. This is where values or ethical based frameworks and guiding principles are required for a positive health service culture.

People work for a health service for a variety of reasons, but they must also unite behind a common purpose. There are values that all at the health service can stand behind, such as patient experience and safety. These are simply rallying points for all staff that also help them when making decisions.

Some examples of values statements in our current health sector include:

- no one is harmed in our hospital(s) / Zero avoidable harm
- patient centred care is at the forefront of everything we do
- health services serve the community and its most vulnerable
- health services have duty to use public funds in an efficient and effective way
- all staff, patients and guests of our health service deserve to be safe and be treated with respect
- stop wasting the patients time.

All health service board’s should consider which values and goals they wish to focus on, that will be a rallying point for all of their organisation to stand behind. When values are included in accountability, it makes the decision making process a greater question than merely personal risk and reward. For example, the DHHS vision is

To achieve the best health, wellbeing and safety of all Victorians so that they can live a life they value

Underneath this, are six value statements with outcomes that DHHS aim to achieve by focusing on these values. These are rallying calls to Victoria’s health sector to not merely rely on compliance but relate to these common values when making decisions.

Embedding innovation

Learning from our successes and failures is one of the most reliable paths for continued improvement. A success or failure is merely a single outcome for that instance. There is a need to act to promote the successful outcome or to prevent/mitigate the poor outcome to maximise the benefit of that learning opportunity. However, to only act once on that outcome risks the ‘knee-jerk’ response which treats learning and innovation as add-ons. A good outcome can be better and a better outcome better again. A poor outcome can have its frequency or impact reduced or avoided.

Blame focuses on the past; accountability focuses on the future. A just culture enables the health service to learn from mistakes.
To succeed in embedding innovation, services require a culture that enables learning as part of core Business as Usual. A necessary element of this is the idea of a ‘just culture’. A just culture should not be confused with merely ‘no-blame’ – for this would neglect accountability. Nor does a just culture seek to prosecute anyone who errs – for this would suppress reporting. A just culture embraces both no-blame and accountability enabling learning from mistakes.

“Blame-free is not accountability free... we can create such accountability not by blaming people, but by getting people involved in the creation of a better system to work in.”

Blame or accountability?

A more constructive way of considering blame versus accountability in a health service setting, particularly from the board’s point of view, is that the person accountable must own the outcome but also the actions to resolve the issue. Blame focuses on the past and the event. While there is certainly a place for understanding how and why a risk crystalised, the purpose of understanding should be to best determine how to avoid or mitigate it being repeated – not to shoot the messenger.

In striving to achieve the best health and wellbeing for all Victorians, the government is committed to ensuring Victoria’s health system has a positive culture focussed on four key areas. These are:

- Safety and wellbeing
- Learning and continuous improvement
- Quality and outcome focussed
- Respect, equity and diversity.  

Not blaming someone for a mistake does not mean there is no accountability or no one taking responsibility. Rather, it shifts the focus to intent and impact instead of focusing purely on persecution of the practitioner/mistake-maker. A ‘just’ culture seeks to provide the health service and the practitioner with the opportunity to:

- take responsibility for the wrong and be accountable
- remedy the error/issue
- ameliorate the impact of the error/issue
- avoid or mitigate future errors/issues of that kind and potentially extend learnings to other situations
- encourage reporting and facilitate a reporting culture.

It should be notable that a just culture provides the opportunity for people to take responsibility for their wrong. Indeed, a just culture does not work without accountability and responsibility for actions.

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124 For example, the Civil Aviation Authority (CASA) will not use safety information in support of disciplinary action IF the reporter/wrong-doer has made taken action to prevent, mitigate, reduce reoccurrence, etc (see CASA reference at the end of the chapter).
This statement should not be controversial but it is worth reflecting on and recalling that blame and accountability are often confused. This is not about persecution of the mistake-maker/practitioner; it is about listening, learning and making positive changes in line with the values of the health service.

It is important that people see and understand both the consequence of an error/issue and the consequence of reporting the error/issue. Reporting an error or issue (even if you were the mistake-maker responsible) should be celebrated and the impact of it communicated. That does not mean there are not consequences for the party responsible, but the consequence should:

- be reasonable and proportionate to the intention of the practitioner
- follow the principles of natural justice
- ensure a focus on learning from the error/issue rather than persecution
- focus on mitigating the impact of the error/issue and preventing future comparable errors/issues
- demonstrate that the health service heard the complaint and acted on it in a way that will not prevent people from reporting in the future.

“It’s important to talk about the positive examples of ethical behavior, not just the bad ones. Focusing on the positive reasons you are in business, and reinforcing the good things people do strengthens ethical choices as ‘the norm’ of the organization.”

- Jonathan Haidt, Professor of Business Ethics at NYU
Principles of an effective health service culture

A strong and robust health service culture needs to include a range of elements. Boards should focus on fostering:

- a ‘just’ culture of safety, fairness, transparency, learning and improvement in which staff are empowered and supported to understand and enact their roles and responsibilities
- a culture based on integrity and ethical standards that are set and demonstrated from the board through to all levels of the organisation
- an innovative, outward-looking culture that is open to new ideas and practices
- visibility of leadership and a board that actively demonstrates the desired conduct and behaviours of the organisation
- an organisational culture that supports staff to pursue safe practice and to speak up when they have concerns (i.e. a culture where ‘bad news’ is OK)
- a culture where conflicts of interest are avoided or managed appropriately and transparently.

Developing a ‘just’ culture

Recent focus has been placed on the development of a ‘just’ culture within the Victorian health services, particularly with respect to clinical governance. The focus is on developing an organisational culture whereby health service staff are supported and their wellbeing prioritised. In practice this requires boards to ensure the development and implementation of systems that support staff in training, development, health and safety (including mental health and wellbeing).

In the context of clinical governance, this is especially important as it involves not only supporting staff, but enabling them to work collaboratively and respectfully with clinicians and consumers in such a way that the overall experience for all participants is as positive and equitable as possible.

Developing a culture where ‘bad news’ is communicated

Recent case studies in the health sector highlight the importance of building an organisational culture that supports the giving and receiving of ‘bad news’ i.e. creating an environment of openness and honesty and the presentation of the hard truth.

Caring for our patients – all voices count

Recently a child was admitted to one of our wards and, during this admission, had a MET Call for tachycardia. A cardiac technician, Jess Cseh was requested to complete an ECG which demonstrated a tachyarrhythmia. Jess attempted to communicate this to the bedside, but her input was dismissed. Instead of accepting this decision, Jess remained concerned and returned to MonashHeart where she escalated the issue to Prof Sarah Hope. Sarah communicated directly with the team involved and ICU regarding appropriate treatment. Fortuitously the arrhythmia settled spontaneously, but recurred later in the admission.

Without the escalation from Jess, this diagnosis could have gone unnoticed by the treating team. Sarah praised Jess for her diligence and for escalating her concerns.

I continue to encourage all staff, no matter what level you are or where you work, to speak up if you are concerned about anything you come across in your work practices.

Andrew Stripp, CEO, Monash Health -Extract from Monash Health’s iNews (3 May 2017).
A KPMG-sponsored survey¹²⁵ found that only 55 percent of respondents believe that their organisation is effective at keeping the board aware of the key risk issues. This is a board culture issue.

A culture where an early warning system for problems exists can provide for timely and appropriate intervention and/or the redefining of strategy. A climate in which full disclosure is delivered in a timely manner should be fostered by senior management and endorsed by the board to encourage employees to immediately bring forth concerns.

This also reflects the importance of ensuring the focus is not on persecution of the reporter and/or person who erred; rather, the focus is on learning from the reported issue/error.

How to identify good and bad culture

In simple terms, organisational culture can be defined as ‘how we do things around here’. In practice, culture represents the way that people within the organisation behave towards each other e.g. how they engage with one another and with patients; the care taken place when performing tasks, the adherence to guidelines and protocols.

Evidence of good and bad culture can be found in a number of ways, and with either quantitative or qualitative information – noting that information can come from a variety of sources. Examples are provided in the table below.

<table>
<thead>
<tr>
<th>Examples of good culture</th>
<th>Examples of poor culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged staff who hold themselves and others to account.</td>
<td>Conflicts between leadership leading to lack of direction for staff.</td>
</tr>
<tr>
<td>Clearly stated values that are displayed prominently throughout the organisation</td>
<td>A disengaged board, CEO and executive that are unwilling to see and hear bad news.</td>
</tr>
<tr>
<td>Leaders conduct regular walk-arounds and ask staff and patients questions related to the safety, effectiveness and person-centred care being experienced and delivered</td>
<td>Isolated and inward-looking culture that is unsupportive of learning and developing and cultivates a fear of speaking up.</td>
</tr>
<tr>
<td>Feedback is welcomed and celebrated as an opportunity to improve.</td>
<td>Clinical leaders who are disconnected from the organisation’s clinical governance processes and systems.</td>
</tr>
<tr>
<td>Staff and clinicians proactively seek and promote improvement opportunities.</td>
<td>Staff turnover and sick leave levels are high.</td>
</tr>
<tr>
<td>There is a sense of pride of the health service amongst staff and the community.</td>
<td>Complaints are left outstanding for long periods of time.</td>
</tr>
<tr>
<td>Staff survey response rates exceed 40 percent.</td>
<td>Suggestions are not given by staff as they feel that any suggestions for improvements have not or will not be implemented.</td>
</tr>
<tr>
<td>Attendance at training or organisational events is high.</td>
<td>Innovation is viewed as an ‘add-on’ and not part of business as usual.</td>
</tr>
<tr>
<td>Work health and safety indicators are positive (low LTIs, low near misses, high quality incident reporting).</td>
<td>Leaders focus on blame rather than learning</td>
</tr>
</tbody>
</table>

Table 11.1 Examples of good and bad culture

¹²⁵ Available from: www.kpmg.com.au
How to address cultural issues

Cultural change doesn’t happen overnight. It is a process of change that can take several months, even years. Given that culture is about behaviours, there can be varying levels of engagement and willingness to change.

Boards can turn the ‘poor’ into ‘good’ and address cultural issues in practical ways that include:

Instruments and tools

- Clearly defining the expected behaviours and values of the organisation.
- Including cultural / value training in board and staff induction.
- Communicating the values clearly within the organisation through both passive (e.g. posters, intranet) and active (including values as part of meetings, language used in emails).
- Reinforce the value in how the board and management communicate (e.g. ‘say it once, say it again and the say it once more’).

Develop cultural documentation (e.g. policies, charters and KPIs).

- Take action in response to patient surveys, staff engagement and community engagement feedback.
- Board member walk-arounds, direct visibility of culture through events (directors should be conscious of how the walk-arounds are conducted).
- Transparency in relation to bad news, empowering staff to raise issues, ensuring appropriate responses to feedback and no attempts to ‘cover up’.
- Board chair actively asks individual directors to speak out during meetings (demonstrating inclusive leadership).
- Designated question time for each board member.
- Celebrating successes in all areas of the health service including having a rewards and recognition program to celebrate staff who exemplify the desired culture
- Look for opportunities to inject good culture into the organisation.

Example ‘above’ and ‘below’ the line behaviours

‘Above the line’ behaviours

- Collegiate and supportive.
- Respectful of the opinion of others.
- Sharing the common purpose.
- Listening and attentive.

‘Below the line’ behaviours

- Aggressive towards others.
- Dismissive.
- Disengaged / distracted (i.e. checking phone/email).
- ‘Gossiping’ or complaining outside the boardroom.

See, for e.g., Peter MacCallum Cancer Centre, Patient Charter (September 2016).

Figure 11-1 #hello my name is one example of a ‘how’ to improve culture between staff and patients

#hello my name is...
Boardroom dynamics

Board culture underpins board dynamics and has a decisive influence on performance. A well-functioning board generally displays coherence, trust and common values between directors, encourages and has regard to differing viewpoints and opinions, and is able to reach a decision without animosity. Healthy boardroom dynamics will encourage sound decision-making that delivers value to stakeholders.

Establishing an effective boardroom culture

DHHS’ Health Service Governance Model Conduct Charter\(^\text{127}\) provides guidance on how health services can define and build an effective board culture. It provides a template for health services to use to develop their own conduct charter and also spells out the key elements of director responsibilities, including:

\(^{127}\) DHHS, Health Service Governance Model Conduct Charter, 2016
The role of the chair in boardroom culture: Inclusive leadership

The chair plays a critical role in facilitating effective boardroom dynamics. Robust, effective discussion should not be confrontational or be domineered by a select few. The chair’s role is to understand the different personalities on the board and ensure that everyone participates equally in the discussion. If a dispute arises in response to poor behaviours, or any other alleged breach of the health services conduct charter, by one or more of the directors, the chair must work with the relevant individuals to find a constructive solution.

If issues continue with board dynamics, it is the role of the chair to raise this with DHHS.

A key strategy for the chair is to continually bring directors back to the goal of their question – this can assist in bringing back a derailed conversation and focus everyone on what is most important.

The Health Services Governance Model Conduct Charter\textsuperscript{128} provides the following guidance on dispute resolution:

In the event that disagreements or interpersonal conflicts could adversely affect the operations of the board, the parties to the dispute and the chair agree to:

\begin{itemize}
  \item work together constructively, promptly and expeditiously to try to resolve the dispute;
  \item keep in mind the interests of the health service at all times;
  \item act in a manner proportionate to the seriousness of the breach, disagreement or conflict;
  \item attempt to address the matter directly and informally in the first instance, with the support of the chair or the Board Secretary where appropriate;
  \item if the dispute remains unresolved for ten working days, consider agreeing to the appointment of a mediator nominated by the chair, or if the chair is a party to the dispute by the Board secretary; and
  \item abide any agreement reached in mediation and also by the ultimate decision of the board (not including the board members in dispute or who have potentially engaged in a breach) about the outcome.
\end{itemize}

The chair will record in his/her own records the nature and outcome of the potential breach, disagreement or conflict. If appropriate, and applying the appropriate confidentiality, the Board Secretary will also record in the matter in the minutes of the board meeting.

If the chair is not displaying ‘above the line’ behaviours and causing friction in the boardroom, directors should raise this with the chair and failing a resolution, seek further guidance from DHHS.

\textsuperscript{128} DHHS, \textit{Health Service Governance Model Conduct Charter}, 2016, p20
‘Poor’ or ‘below the line’ behaviours should not be displayed – or tolerated – by any director.

More information on the role of the directors and the chair is in Chapter 8: Productive meetings.

The board’s relationship with management

The working relationship between directors and management is one of the most influential factors in board effectiveness. Most productive relationships are built on mutual trust and respect, where both the board (and the chair in particular) and the CEO work in partnership, each with an acute appreciation of the vital role played by each other in building stakeholder value. Dysfunction can occur where either the chair or the CEO is overly controlling and this behaviour goes unchecked.

“...organizational culture can dramatically affect both ethical conduct and reporting of misconduct, by establishing workplace norms, harnessing social identity and group loyalty and increasing the salience of ethical values.”

Shouldn’t need to be said...

It is a key responsibility of the Chair to ensure appropriate behaviour from the CEO and other presenters to the board, as well as the board’s behaviour to those presenters (and each other). Often behaviours are not discussed because many assume that it goes without saying that the behaviour was inappropriate – this assumption should not be relied upon. A board is composed of people from very different backgrounds and experiences and it is important that both the standard of behaviour expected is clear and that when that behaviour is not shown, it is corrected.

As the leaders of the health service, the board should role model both appropriate conduct and correcting inappropriate conduct in a fair and just manner. It should be clear to any person looking in that the board will not condone behaviour that intimidates, belittles or harasses another person.

Useful references


- Civil Aviation Safety Authority, Limitations on the use of safety information CASA, (February 2017), Ref D17/287921, Australian Government.


• McSherry, Robert and Paddy Pearce, *What are the effective ways to translate clinical leadership into health care quality improvement?*, (2016), Journal of Healthcare Leadership, 2016:8: 11–17. Published online Feb 2016: www.ncbi.nlm.nih.gov/pmc/articles/PMC5741002/


• Thomson, Louisa, *Patients in control: ‘assume it’s possible’*, (May 2015), The Office for Public Management Ltd (OPM), UK. Available from OPM here: http://www.opm.co.uk/uncategorized/patients-in-control-assume-its-possible/


**Example ‘hows’**


• Civil Aviation Safety Authority, Limitations on the use of safety information CASA, (February 2017), Ref D17/287921, Australian Government.


• Granger, K and Pointon, C, #Hello my name is (2014). Available here: https://hellomynameis.org.uk/


12. Accountability and performance

Health services are accountable to its primary stakeholders: the Minister, the Secretary and DHHS. Health services also have ancillary accountability to consumers as well as the health sector and broader community. The nature of the services provided means that accountability is key to maintaining credibility and the ultimate longevity of the health service. Achieving this comes from transparent and accurate disclosure and reporting of financial, clinical and operational performance.

Questions that directors of health services should ask

- What is the board’s performance and reporting obligations and:
  - How do I meet them?
  - What are the significant risks in meeting/not meeting them?
- What is happening in or around the health service that could be impacting on performance?
- How is the board measuring the effectiveness of its relationships and engagement with stakeholders to which it is directly accountable - such as DHHS, the Minster, Secretary and regulators?
- How is the board measuring the effectiveness of its relationships and engagement with additional stakeholders (e.g. staff, health service providers, patients, the broader community, regulators)?
- How well does the board understand the needs of the community (as opposed to their wants)? How is this balanced against the capacity and capability of the health service?
- What are the key metrics, benchmarks and performance thresholds that I need to understand and monitor?
- What are the implications for the health service if these KPIs are not met?
- Could I explain the importance of these measures to a layperson?
- How confidently could I describe the performance of the health service without assistance from management?

Red flags

- There is an increasing level of scrutiny from the DHHS or other key stakeholders (the Minister and Secretary).
- DHHS voices concerns regarding some of the organisation’s governance practices.
- There are significant media leaks.
- DHHS expresses concern regarding the timeliness of the organisation’s reporting.
- The organisation’s business model is not clearly articulated in external communications.
- AGMs and Open Access Meetings are difficult, with challenging and unexpected questions posed by consumers and members of the community, the DHHS, the Minister or Secretary.
- There are key issues at a system level.

130 Note that the HLA Bill will provide for the functions of the board to include taking into account the view of the community and users of a health service in their planning. Refer to the summary of HLA Bill changes in Chapter 1.
Introduction to the chapter

The notion of accountability is at the core of any corporate governance framework. Unlike corporate entities, Government entities are not subject to demands and expectations of stakeholders in the traditional sense, however, as tax-payer funded organisations, boards must remember their duty to responsibly oversee the performance of the health service and accurately report on this to the relevant authorities. This chapter includes:

- an overview of the key external accountabilities of health services, such as the publication of Annual Reports, development of the SoP and Strategic Plan.
- an overview of the framework used by DHHS to monitor and assess the performance of health services and their boards.

HLA Bill accountability changes

There are a range of changes to the accountabilities of the board and CEO from the HLA Bill (to be proclaimed on or before 1 July 2018). These are detailed throughout this toolkit with a full summary at the end of Chapter 1. Accountability and performance chances but can be summarised as follows:

- The Minister's power to appoint a delegate to a board now includes circumstances that would improve the establishment of a new entity (e.g. a new public hospital) or improve quality and safety
- The Minister can public guidelines relating to the role and procedure of boards and how they carry out their functions (for example, deputy chairperson requirements)
- Functions of the board include development of a strategic plan, monitoring of the implementation of plans and performance management of the CEO
- Functions of the CEO includes implementation of the strategic plan
- Reasons for Powers of the Minister to be exercised (such as appointing an administrator or closing the service) to include whether the service:
  - has failed to provide safe, patient-centred and appropriate health services; or
  - has failed to foster continuous improvement in the quality and safety of the care and health services it provides

Key accountability documents

There are several key documents that health services must prepare to demonstrate accountability to the Victorian Government:

- Strategic Plan
- SoP (or equivalent agreement)
- Annual Report
- Victorian Quality Account
- accreditation (not a document, but a process that also demonstrates accountability).

These documents are required under the DHHS PFG\textsuperscript{131} and PMF\textsuperscript{132}.

\textsuperscript{131} DHHS, Policy and Funding Guidelines are available from: \url{https://www2.health.vic.gov.au/about/policy-and-funding-guidelines}
Strategic Plan

The Strategic Plan (prepared every 3-5 years) must be approved by the Minister. Its purpose is to provide a three to five year outlook of the health service including:

- role and objective of the health service
- strategic objectives over the three to five year period
- strategies adopted to deliver on these objectives
- strategies adopted to ensure effective and efficient provision of health services
- strategies employed to ensure the financial sustainability of the health service

The Strategic Plan sets the overall context for the annual SoP and the two documents should therefore align.

The development of the Strategic Plan is one of the most important tasks of health services boards. Strategic planning development and review must be part of the annual agenda for each board.

New HLA Bill Strategic Plan requirements for public hospitals and MPS

The HLA Bill will provide that the development of a strategic plan will be one of the functions of a public hospital and/or MPS board consistent with the requirement for public health services under section 65S of the HSA. This will form part of the new section 33(2) and 115E(2)(d) of the HSA once the HLA Bill is proclaimed.

A strategic plan will not be automatically required per se, rather, the Secretary can direct a board to prepare one for the Secretary to approve. Should the Secretary require the board to produce a strategic plan, the board would be required to advise the Secretary if it wishes to exercise its functions in a manner inconsistent with the approved plan.

Statement of Priorities (SoP)

The SoP is an annually prepared accountability agreement between Victorian health services and the Minister. It is an important document as it details the key accountabilities of the health service.

The Enabling Acts specify that the SoP must:

- align with the Strategic Plan
- specify the services and funds to be provided by and to the health service
- include the objectives, priorities and key performance outcomes to be met by the health service
- detail the KPIs, targets and measures used to assess and monitor the performance of the health service
- include details of how and when the health service must report to the Minister (or Secretary) on its performance
- any other matters agreed by the Minister and board, or determined by the Minister.

Note: The HLA Bill makes the key accountabilities of SoPs more consistent across the various health services.

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Refer note on the next page regarding the impacts of the HLA Bill on the requirement to produce strategic plans for public hospitals and MPS.

See clause 20 of the HLA Bill which will insert new sections 40F, 40G, 40H into the HSA.
by amending the three Enabling Acts (the ASA, MHA and HSA). However, early parenting centres and MPS will continue to have alternative agreements to the SoP (a health service agreement and tripartite agreement respectively).

**Key responsibilities of the board** in developing the SoP include:

- development of the SoP must be done collaboratively between the board and DHHS with input from the CEO
- the chair must sign the SoP (as well as the Minister or Secretary) by the 1 October each year
- development of KPIs must align with the performance and policy framework across the various performance areas.136

The SoP also includes details of reporting requirements of the PFG. Directors should ensure that they are aware of these requirements, including data requirements, so that they can ensure compliance and accountability to DHHS.

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**New HLA Bill SoP requirements for public hospitals**

The HLA Bill inserts a new section 40G into the HSA which requires the boards of all public hospitals (except for early parenting centres) to prepare, in consultation with the Secretary, a SoP. If the public hospital and Secretary fail to agree on the SoP by 1 October of that year, the Secretary can make a SoP for that public hospital in accordance with the approved strategic plan for that service.

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**Annual reports**

All health services are required to prepare and lodge annual reports to Parliament. The reports must be prepared in accordance with the FMA and *Standing Directions of the Minister of Finance* under the FMA and *Financial reporting directions*137. The Standing Directions require that all annual reports must be prepared in accordance with Australian Accounting Standards and Interpretations (AAS) as issued by the Australian Accounting Standards Board (AASB).

Preparation of the health service’s annual report is a key accountability of the board. It contains critical information about the health services performance and is not only submitted to Parliament, but also available to the public. The annual report must include:

- report of operations including reporting against performance in line with the SoP
- financial statements (including explanatory notes).

The PFG’s are available to assist directors meet the minimum requirements of the FMA and Standing Directions. This guidance (provided by DTF) contains the relevant directions with respect to report content, accounting treatments and the required disclosures regarding the health services’ operations, financial and non-financial performance. The guidance also includes a model report that is a template for all public sector entities.

In order to publish these annual stakeholder reports, boards must review and interpret financial and clinical data on a regular basis. A range of reports will need to be tabled at board meetings at regular intervals throughout the year. The board’s annual agenda (refer to Appendix 6) should outline what is to be reviewed and when, so that nothing is missed.

More guidance on interpreting financial and clinical data is provided in the *Chapter 13 - Financial governance* and *Chapter 14 - Understanding data*.

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136 Review the most recent PMF to determine the current performance areas: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring

**Victorian Quality Account**

Clinical services are the mainstay of health services and ensuring they are provided to the highest standards is ultimately the responsibility of the board. Quality and safety indicators not only reflect the level of care that is being provided, but also the effectiveness of systems and processes to ensure these levels of care are maintained and improved.

The Victorian Quality Account is a mandatory report produced annually by each Victorian health service provider. The report describes the systems and processes in place to monitor and improve health services.

The annual Victorian Quality Account ensures accountability of health services, promotes system changes and continuous improvement, and provides consumers with information.

The publication of the Victorian Quality Account is a condition of health service funding, and must be submitted to DHHS annually.

The Victorian Quality Account is designed to:

- ensure accountability of health services
- promote changes in systems and professional practices
- promote continuous improvement
- provide consumers with information.

Additionally, there are minimum quality and safety reporting requirements set out in the PFG. The guidelines are updated annually (by 30 April) and include:

- reporting of performance outcomes for key quality and safety indicators (such as infection control, medication errors, falls prevention and management, pressure wound prevention and management)
- details of the health service’s assessment against the Victorian clinical governance framework
- accreditation outcomes
- details of clinical risk management systems and processes (including credentialing, scope of practice and certification of staff)
- complaints management processes and outcomes.

The report must be presented in accordance with standard guidance provided by DHHS under the Victorian quality account reporting guidelines. This guidance covers both the format and the content (including specific KPIs) that must be included.138

Safety and quality data is captured centrally by the Victorian Government through the VAHI and available for health services to view and download in order to benchmark their service against that of others (Refer to Chapter 14 - Understanding data).

**Accreditation**

Just as all clinical practitioners must be accredited to provide services in their relevant area of practice, health services themselves must also be accredited. Accreditation is a formal process that ensures that all public health services maintain the highest standards of quality and safety, and deliver continuous service improvements. All health services are regularly measured and assessed in against the Australian Health Service Safety and Quality Accreditation Scheme.

There are ten NSQHS Standards that health services must meet and maintain, showing clear evidence of the systems in place to ensure high quality clinical and safety outcomes. Accreditation to the national standards ensures that all Victorian health services have rigorous and consistent safety and quality systems.

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of

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health service provision. It is important to remember they provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

**Director responsibilities: performance monitoring and reporting**

The importance of performance monitoring and reporting cannot be understated. The critical areas of access and timeliness; governance and leadership; financial performance; and quality and safety underpin the health service and must be accurately captured and reported as a means of the health service being accountable to its stakeholders and continuously improving.

Directors must therefore be confident in their abilities to understand the data and information that is presented to them by management (or other sources). This requires directors to have a sound level of financial literacy and clinical understanding, to enable them to question, probe and challenge the information.

Boards are in a unique position to step back from the day-to-day perspective of management and view the organisation from all perspectives. Boards should be able to assist in improving the quality of reporting by identifying any major gaps between what is being reported to stakeholders by management and what should be reported, whilst having regard to stakeholder needs, concerns, influences and decision-making behaviour.

**Performance monitoring**

DHHS is responsible for monitoring the performance of health services, with expectations articulated primarily in the SoP or service agreements.

*Targeting Zero* found while Victorian hospitals deliver some of the best care in the world, the current oversight arrangements are insufficient to provide the necessary level of assurance that hospitals are consistently providing safe and quality care.

The review recommended a complete overhaul of the performance monitoring system focusing on a risk assessment approach that targets patient outcomes, governance and culture and incentivises continuous improvement.

The updated *Victorian health services performance monitoring framework* details DHHS’ continual improvement performance objectives within four key domains (refer to Figure 12.1):  

- high quality and safe care  
- strong governance, leadership and culture  
- effective financial management  
- timely access to care.

![Figure 12-1 Performance objectives and domains (Source: Victorian Government)](image-url)
These domains have been selected as most relevant to supporting best patient outcomes. Measures of performance inform each of the domains, some demonstrating achieved outcomes (reduced harm, improved patient experience) and others measuring anticipated risks that could potentially impact performance (e.g. workforce safety and engagement).

A health service needs to demonstrate continual improvement in each objective to demonstrate achievement of the performance domains. The framework outlines the approach that health services can take to achieve performance improvement. The approach follows a continuous cycle (refer to Figure 12.2) whereby DHHS works collectively with health services and stakeholders to:

- identify performance concerns and other risk flags
- analyse the level of risk and opportunities for improvement
- determine appropriate interventions
- ensure that action is taken to mitigate risk and support ongoing improvement.

DHHS works with health services to understand the factors that may contribute to performance and to support health services to improve performance where challenges have been identified.

If remedial action is required an escalation process is followed, which involves an initial discussion with relevant health service executives. The board may also be involved in discussions to reach an acceptable resolution.

Where service improvement is required, a plan for improvement is agreed between the health service and DHHS. Where the improvement required relates to quality and safety, SCV will also provide expert input into the development and progress of Quality and Safety improvement plans.

Outcomes from the performance assessment determine the different levels of monitoring, support and intervention required. Monitoring levels are determined quarterly and board involvement (via board chairs) is expected for health services identified as requiring intensive monitoring.

DHHS may increase monitoring levels of health services where:

- there is significant non-performance with respect to agreed expectations and targets
- there is a major risk to community safety.

Serious concerns may necessitate more drastic action including an independent review of health service governance and management capability. This may include the board chair being required to demonstrate that the organisation is able to address the concerns within a reasonable timeframe, change to membership of the board and/or appointment of an administrator or delegate. The Enabling Act sets out the powers of the Minister regarding inadequate performance.¹³⁹

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¹³⁹ See, for e.g., Health Services Act 1988 (Vic) section 58.
The following table depicts how DHHS classifies health service performance with descriptions of the general monitoring and intervention strategies that will be applied:

<table>
<thead>
<tr>
<th>Monitoring level</th>
<th>Monitoring, support and intervention strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High performer</strong></td>
<td>Quarterly meetings with the department. Strategic discussion for further improvement or system leadership opportunities.</td>
</tr>
<tr>
<td><strong>Standard Monitoring (with or without risk mitigation in train)</strong></td>
<td>Quarterly performance meetings. Routine performance risk assessment. Progress update on risk mitigation plan, where relevant.</td>
</tr>
</tbody>
</table>
| **Performance Support** | Closer monitoring of performance and remediation plan progress by the department until issues resolved. Six weekly or more regular performance meetings as determined by the department. Support to undertake and sustain improvement by:  
  • engaging an independent expert to review clinical practice, governance or financial concerns and make recommendations for improvement  
  • seeking SCV ‘s input and support with further improvement  
  • appointing an independent expert to the Health Service’s Safety and Quality committee. |
| **Intensive Monitoring** | Monthly performance review meetings. Discussions between DHHS and the board chair regarding strategies related to governance, leadership and culture that may have an impact on performance improvement goals. More direct intervention including imposed external service review and/or appointment of a board delegate. |

*Table 3 Performance monitoring and intervention strategies (Source: Victorian Government)*

**Performance monitoring roles and responsibilities**

Health services, under the governance of board directors, are responsible for:

- partnering with DHHS and other agencies to improve health service and system wide performance
- reporting promptly to DHHS any emerging risks or potential performance issues including immediate action taken
- establishing and maintaining a culture of safety and performance improvement within the health service
- ensuring accurate and timely submission of data and other information, including formal risk mitigation plans and status update reports
- collaborating with other health services and health system partners to meet the health needs of their communities.

The framework consists of a formal monitoring and meeting cycle, which specifies the roles and responsibilities and performance monitoring tools that are available to health services.
DHHS has overall accountability to:

- implement the new risk based performance monitoring approach and associated tools
- partner with health services to identify and mitigate performance risks early and effectively
- support or intervene to ensure long term and sustained performance improvement
- facilitate better sector consultation and communication, including information on departmental policy directions and sharing with other relevant agencies
- make better use of available data and third party intelligence
- maximise input from SCV and other experts/clinical leaders
- enhance board skills and capabilities in clinical governance and other information required to ensure high quality and safe care
- provide staff with training and mentoring in performance management and quality improvement and the tools to enable them to have an effective performance improvement role.

Performance monitoring tools

As determined by legislation, the SoP is the key service delivery and accountability agreement between health services and DHHS. It outlines key deliverables and performance targets to be achieved by the health services within the allocated annual budget. Performance against these is monitored via the Victorian Performance Monitor Report (Monitor) and other methods as follows:

**Monitor**

The Monitor reports health service performance against the performance indicators and measures outlined in the SoP. A similar performance monitoring tool is produced for AV and Forensicare.

The Monitor is produced monthly, and provides interim results of indicators and measures across each performance domain. It is distributed monthly to CEOs, the Ministers for Health, Ambulance Services and Mental Health, and quarterly to board chairs.

The Monitor is also produced annually using the consolidated annual activity data and audited financial results. This is distributed to health service CEOs, board chairs, and the Ministers for Health, Ambulance...
Accountability and performance

Services, and Mental Health.

The Small Rural Health Services Monitor (SRHS Monitor) reports on small rural health service performance against the indicators outlined in the SoP as well as a broader set of program measures on health service activity. The SRHS Monitor is also produced for the multi-purpose services. The SRHS Monitor is distributed to CEOs and the Minister for Health monthly, and to board chairs quarterly. An annual SRHS Monitor report is produced using the consolidated annual activity data and audited financial results. This is distributed to CEOs, board chairs and the Minister for Health.

The Monitor will continue to be the primary tool for monitoring compliance against the key deliverables and agreed performance targets set out in the SoP.

In addition, performance against the actions and deliverables committed to in the SoP are formally reported in health services’ annual reports at the end of the financial year as consistent with the annual report guidelines (report of operations). Health services are expected to also provide a half yearly progress report on achieving action items and associated deliverables in Part A of the SoP.

Program Report for Integrated Service Monitoring (PRISM)

Monitor is supported by a broader set of measures under the PRISM. It provides further context of performance and supports health services to further benchmark their performance against similar health services. For the small rural health services, this information is incorporated in the SRHS Monitor.

The PRISM report is distributed to CEOs and board chairs quarterly. DHHS encourages health services to disseminate PRISM to relevant staff within their organisation. An annual PRISM report is produced using the consolidated annual activity data and audited financial results. This is also distributed to CEOs and board chairs.

Inspire

As of 2017-18, the Quality and Safety measures reported in the PRISM report will be consolidated and expanded into a new report referred to as ‘Inspire’.

Clinical data and analysis plays an important role in the performance monitoring framework. Inspire is a service designed by VAHI specifically for use by clinicians, with the intention of supporting conversations on safety and quality performance among clinicians and health service management. It contains more granular data than Monitor and PRISM, so it is not within the direct remit of the board to be reviewing the information. However, board directors should seek regular summaries and updates from management as part of their clinical governance role.

Board quality report

VAHI also prepare the Board Safety and Quality Report. It is produced specifically for the attention of the board and aims to increase access for boards to independent information on the performance of health services. It is intended to supplement the information already provided to boards by their executives. The report is issued quarterly to the board chair of each health service.

Consistent with the new performance framework objectives and Targeting Zero report recommendations, in addition to the above, other assessments, ad-hoc reports and cross-agency intelligence will be used to inform the performance analysis.

The method by which this is achieved, is described in detail in the PMF.

Audits by the Victorian Auditor-General

An important control in the accountability framework for all Victorian public sector health services is the independent audit (as opposed to a review) of the organisation’s financial statements and clinical performance. VAGO undertake audits to provide Government and the community with a level of confidence that the reports presented, and therefore the viability of the service, have been independently verified. The Victorian Auditor-General reports are publicly available and therefore it is important that material issues are avoided through the use of effective governance processes.

Audits are designed to obtain sufficient, appropriate evidence so the auditor can express a positive opinion that the financial report provides a ‘true and fair’ view of the organisation’s financial position and
performance. The auditor draws on evidence from organisational and external sources, using, where appropriate, the organisation’s internal controls and results obtained from testing of these controls. An audit provides a high, but not absolute, level of assurance on the financial information.

VAGO publishes its annual program of work and the reports the outcomes of each review on its website.¹⁴⁰

The role of committees in accountability

Committees are a mechanism through which boards can focus attention on key responsibilities without distracting the board from its other important functions. These can be outlined in the by-laws but should also have their own terms of reference. Committees can be standing committees, or they can be established by the board to undertake more detailed review of a particular, short term issue.

Health services must establish three key committees:¹⁴¹

- **Audit and Risk** – to focus on the specific requirements of the financial reporting, risk management and assurance functions (including internal and external audit).
- **Quality and Safety** – to focus on clinical risk management and performance issues in a more detailed way.
- **Finance** – to focus on the financial performance of the health service, including financial reporting and systems (outside audit processes).

Committees are important mechanisms for ensuring accountability to stakeholders as they allow for more detailed examination of these three key areas. Committees also provide time and resources for external assurance and advice to ensure independence and credibility of the reported data – both financial and non-financial.

Other useful committees are:

- **People and Culture** – focusing on human resource issues, staff engagement, and may also include Work, Health and Safety.
- **Community Advisory** – an advisory committee that includes members of the community, such as charities, community service providers and/or general members of the community/users of the health service. The committee is an important stakeholder feedback mechanism for the board.

Effective committees are defined by key characteristics, including:

- has clear terms of reference that outline the purpose of the committee, its composition and responsibilities to the board
- compromises board directors and any additional advisors or subject matter experts that are deemed necessary for the committee to meet its objectives
- appoints a chair that is not the chair of the board.
- includes the appropriate mix of skills and experience to enable it to meet its objectives.

Being part of committees is an additional responsibility of directors. As for board duties, directors need to ensure that they have the appropriate skills and capacity required to fulfil any additional committee duties. Committees provide the opportunity for more detailed consideration of key issues and therefore the need for directors to challenge, question and provide stewardship to the health service is just as – if not more - relevant as when in the boardroom.

While the existence of an audit committee does not alter the need for directors to take responsibility for the financial reports, with the ultimate responsibility for a health service’s financial statements resting with the board, audit committees can play an important role in the financial reporting process and in supporting and promoting audit quality. A separate audit committee can be an efficient and effective mechanism to

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¹⁴¹ Please note this is a mandatory requirement for public health services as defined in the HSA however it is recommended best practice even where not mandatory.
bring the transparency, focus and independent judgement needed to the reporting process.

The audit committee typically focuses on a limited range of key issues for reporting purposes. It should review:

- any significant accounting and reporting issues, including professional and regulatory announcements, and understand their effect on the health service’s financial statements
- all half-year and annual financial statements of the health service, and any other periodic disclosures, that require approval of the board (the process typically culminates in a detailed page-by-page review by the audit committee of these reports with the external auditor and management present)
- the written statements provided by the CEO and CFO for reporting purposes under the requirements of the HSA (or other Enabling Act), and the FMA
- all related party transactions for potential conflicts of interest, providing approvals on an ongoing basis.
Useful references

- Leggat, Sandra G and Balding, Cathy, *Bridging existing governance gaps: five evidence-based actions that boards can take to pursue high quality care*, (2017) Australian Health Review ([https://doi.org/10.1071/AH17042](https://doi.org/10.1071/AH17042)).
13. Financial governance

A high performing health service is one that not only provides high quality, safe clinical care, but is also financially viable and sustainable. Directors must actively monitor the health service’s financial performance in the context of health service funding mechanisms in order to effectively fulfil their directorial and Minister appointed responsibilities.

Questions that directors of health services should ask

- Am I fully aware of my responsibilities with respect to governance of the financial performance of the health service?
- Do the board understand activity based (i.e. funding based on outputs) versus non-activity based (i.e. block funding/program funding) funding?
- Does the board understand the health service’s demographic and its relative casemix?
- How is the board getting assurance that its financial risks are being managed effectively?
- Is the information being reported by management aligned to our strategic objectives?
- What are the major financial risk areas that our health service is, and will be, exposed to?
- Does the board have an understanding of financial risk thresholds and tolerances, to enable identification and escalation of risk mitigation actions?
- Does the board have a clear view of how the health service performs against other services?
- Does the board regularly engage with external advisors to detect and understand issues?
- What checks and balances are in place to monitor the effectiveness of financial risk management strategies? What are our integrity controls (e.g. separation of approver and purchaser)?
- What are our cash flow patterns? Is our expenditure reasonable in the circumstances?
- Are we being provided financial forecasts by management that helps ensure future risks are known?
- Do I have the required financial literacy to make informed decisions in relation to the governing of the health service as required under the FMA?

Red flags

- Financial reports from management are approved by the board without question.
- There are no directors with financial or accounting skills on the board.
- Variance and trends in financial performance data are not discussed or questioned by directors.
- Directors do not understand deficit funding and how revenue is recognised.
- Performance reports are provided in an ad hoc manner and/or inconsistent format.
- Directors leave questioning of financial performance data to the 1-2 specialists on the board.
- Financial surprises occur when rectification takes place at the end of financial year.
- Directors are unable to articulate the top financial risks faced by their health service.
- No benchmarking of financial performance is undertaken.
- Funding issues emerge ‘without warning’ and the board spends too much time dealing with emergency financial risk situations.
- The board does not regularly consider how it could be reducing costs, such as input costs and matters that can be outsourced or provided in partnership to reduce net costs.
• The board is not aware of HPV and its role in the Victorian health system.

Introduction to the chapter

This chapter goes through how health services are funded, specific funding models and provides information for directors with respect to their individual and collective responsibilities in relation to financial governance as well as applicable legislation and Victorian Government policies.

Financial governance underpins the monitoring of a health service’s ability to provide ongoing, safe and quality health care to the community and is therefore closely aligned with clinical governance – both with respect to the importance of the issues and the governance processes applied.

How health service budgets are set and relevant funding models

The DHHS initially negotiates its fixed health budget with DTF. Once this figure has been agreed the DHHS then determines the funds to be allocated to health services.

The DHHS then negotiates with each health service with respect to the provision of nominal budgets for the following (where applicable to the health service):

Variable funding i.e. activity based funding (ABF)

• Calculated as the agreed volume of activity at the agreed prices.
• Activity targets are set to manage performance and demand.
• Funding is output based.
• Different prices for different types of activity are set to manage financial risk.
• Typically represents about 60% of a health service’s budget (SRHS are not funded through ABF).

Fixed or block funding (specified grants)

• Funding is input based – For example, funds are provided to keep an emergency department running regardless of whether patients attend.
• Funding is indexed by population growth and the Consumer Price Index.
• Currently, this is the primary funding model for SRHS.

Please note, not all health services will be funded by both models, some may only be funded with block funding.

Activity based (WIES/NWAU) funding recognises the costs as a result of the patient’s complexity, needs and length of stay.
In 2017-18, Victoria uses a combined approach, which utilises both ABF and block funding approaches. A health service may receive funding under all of the following (this is not an exhaustive list):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Funding description</th>
<th>ABF or block funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Non-admitted emergency services grant</td>
<td>Block</td>
</tr>
<tr>
<td></td>
<td>Group C accident and emergency grant – this is the regional equivalent of an emergency department (as some emergency presentations are seen)</td>
<td></td>
</tr>
<tr>
<td>Admitted acute (this includes those admitted from the emergency department)</td>
<td>Weighted Inlier Equivalent Separations (WIES)</td>
<td>ABF</td>
</tr>
<tr>
<td>Admitted subacute</td>
<td>Subacute Weighted Inlier Equivalent Separations (subacute WIES)</td>
<td>ABF</td>
</tr>
<tr>
<td>Non-admitted acute</td>
<td>Weighted Ambulatory Service Events</td>
<td>ABF</td>
</tr>
<tr>
<td>Non-admitted subacute</td>
<td>Available bed days</td>
<td>ABF</td>
</tr>
<tr>
<td>Admitted mental health</td>
<td>Health Independence Program</td>
<td>Block</td>
</tr>
<tr>
<td>Non-admitted mental health</td>
<td>Various ambulatory contact hour grants</td>
<td>Block</td>
</tr>
<tr>
<td>Some training (e.g. pre-vocational medical training)</td>
<td>Specific grants</td>
<td>Block</td>
</tr>
<tr>
<td>Other</td>
<td>Various block grants to subsidise existing funding models to support programs that are not equitably funded e.g. high cost, low volume</td>
<td>Block</td>
</tr>
</tbody>
</table>

*Table 4 - Health service funding (Source: Victorian Government)*

As you can see from the table, not everything is ABF. For example, SRHS are funded through block funding. However, as ABF forms a significant part of health service funding, the following section discusses what ABF consists of (with WIES being the main example of ABF), some limitations of the ABF model (and why it is not used in all circumstances) and some case studies to help explain how ABF works in practice.
Activity based funding - ABF

ABF uses classifications, called diagnosis related groups (DRGs), which bundle patient care episodes into clinically coherent groups that require similar resources. Simply put, health services are funded based on activity. In Victoria, the ABF model is used to monitor, manage and administer the funding of healthcare provided by a number of health services.¹⁴²

The ABF model is continuously refined in order to:

- promote funding policy objectives
- better moderate financial risk
- maintain funding equality
- align funding with clinical practice changes and new technologies.

How ABF allocation works

The ABF model allocates funds based on:

- the types of patients treated - Patient types are determined by using information from patient medical records to group patients into DRGs. This is discussed in detail below under WIES.
- the number of patients treated; and
- length of stay (LoS).

Weighted Inlier Equivalent Separation (WIES): An ABF unit for admitted acute patients

The Victorian WIES model (used for admitted acute patients) is the main ABF model that allocates funds in recognition of the relative costs and complexity of different patients.

As such, each patient episode of care is grouped to a specific DRG, which reflects the costs incurred by health services in treating the patient.

Patients admitted in accordance with the funding model will generate differing amounts of WIES as a result of their care needs, with the health service being paid by DHHS at a

Case study – How external factors and a change in patient profile influence ABF

Better Care Service (BCS) is a specialist hospital, with a large portion of their services catering for maternity services. Additionally, they operate a 24 hour emergency department and undertake elective surgery procedures (acute admitted patients).

BCS’ service mix has been established to cater for the demand of a relatively young and growing population on the fringes of Melbourne, and is located in a high growth corridor. In recent years however, BCS has experienced slow revenue growth and has moved from generating small but healthy operating surpluses, to a small deficit in the most recent financial year.

In the current year, revenue is tracking behind the health service’s forecasts. The CFO and CEO have reviewed patient numbers, which continue to show strong growth experienced over the last few years. However, within this they have identified a shift in the complexity of births over the last 2 years. This shift attracts lower revenue based on the lower complexity associated with it in the funding model. Further, overall births have remained relatively stable, whilst other areas of their hospital, such as their emergency department have grown significantly.

Given the hospital had established its cost base on the traditional patient mix, they have identified that this shift in birth complexity and the increase in demand for other services, has now started to impact on their traditional revenue streams while simultaneously experiencing additional costs in their ED.

The health service is now looking at ways to restructure its staff profile and cost structures to cater for these changes. Funding will now be modified based on the changing demographic and demand as a result. This is an example of how ABF adjusts and changes over time as health services adapt to cater for their population and demographic changes and health service demands.

Health services cannot control these ever changing demands however must be aware that these changes can drastically impact health service funding.

standard rate for each WIES recognised.

The DRG takes into account a range of factors in order to arrive at the relevant cost e.g. how many hours of surgery, how much electricity required, length of stay, staff (including specialities) required and various other factors.

For example, a sleep disorder has a relatively low DRG weight of 0.2. A liver transplant has a relatively high DRG weight of 25. This recognises the differing needs and complexity of each patient and the WIES generated by the health service will vary accordingly.

A single WIES has been calculated as approximately $5,000 (being the average cost of treatment for one episode of care in Victoria). Therefore, the DRG for a sleeping disorder will impact the total WIES amount. So, for that episode of care, the funds allocated to the service will be calculated as follows:

\[
0.2 \text{ (W)} \times \$5,000 \text{ (IES)} = \$1,000
\]

Five (5) separate episodes of care for sleep disorders will equate to 1 WIES:
(i.e. \$1,000 \times 5 = \$5,000)

**How are DRGs assigned to patients?**

When a patient enters a health service, displaying or stating various symptoms, health practitioners assess the patient and collect a medical history. This information is then used by coders to group the patient to a specific DRG and can include (but is not limited to):

- the patient’s diagnosis
- any particular complications
- previous procedures a patient has had
- age
- co-morbidities.

The information that health services report about their patients is then used to work out the ABF (e.g. WIES) health services receive.

DRGs are based upon the reported costs of treating patients as provided by the health service to DHHS.\(^{144}\)

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**Case study – WIES**

At Better Care Service (BCS), 2 newborn babies are transferred to the neonatal ward. Both babies were born prematurely, one weighing 1,499 grams (Child 1) and the other weighing 1,550 grams (Child 2). Each child in this case has the same length of stay and is provided the same care needs.

While the weight difference is only 60 grams, this places each child into a different DRG, which impacts the average cost associated with each child:

- **Child 1**: 19 WIES
- **Child 2**: 10 WIES

As compared to their associated DRG cohorts, the calculated, average length of stay for a child similar to:

- Child 1, is approximately 32 weeks
- Child 2, is approximately 21 weeks.

While there is a small weight difference and each child is given the same care needs in this case, given the structure of the funding model, and how each child is identified by it, Child 1 is allocated a greater amount of WIES on the basis of the different DRG.

The reason for this is that Child 1 has been recognised by the funding model as, on average, although not in this case, a more complex patient, due to the weight difference requiring more care (which includes specialist equipment and staff), and have an increased length of stay in the health service.

This has potential implications for BCS as factors in the surrounding population can change, such as diet and physical activity, which impacts average birth weight. The resulting affect is an increase in cost due to more babies born under 1,500 grams.

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\(^{143}\) The actual value varies year on year with funding model changes. As such, $5,000 has been used as a simple, round-number approximation for the purpose of this toolkit. Refer to the PFG each year for the actual value.

NWAU – what is the difference?

An NWAU is the national version of a WIES; in other words, it is an ABF unit. It is much like comparing metres and yards – both measure the same thing in the same way, but are just a slightly different size.

Limitations of ABF

Each and every patient in a DRG is funded at the same amount (a flat rate of funding). However, not every patient in a DRG needs exactly the same level of care.

A flat rate of funding may not adequately track cost variation across time and levels of severity within a DRG. For example, some:

- groups of patients require additional care, even within the same DRG, therefore the costs to treat them exceed the DRG.
- health services treat more complex patients due to their speciality.

This approach can create financial risk to providers and purchasers of healthcare.

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145 Refer to the Independent Hospital Pricing Authority at [https://www.ihpa.gov.au/](https://www.ihpa.gov.au/)
WIES – Questions for board directors to ask if your health service is not meeting its targets

This information is included to give you a better understanding of how health services are funded and to arm you with the knowledge to ask the right questions of your executive team, assuring yourself that the health service remains financially viable.

If your health service is:

- not meeting its ABF targets (e.g. admitted acute patients - WIES); or
- exceeding projected ABF targets and spending more than anticipated (e.g. admitted acute patients - WIES).

<table>
<thead>
<tr>
<th>Questions</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| Has our patient cohort changed?  
<i.e. has the population demographic changed?</i>  
See the ‘how external factors and a change in patient profile can influence ABF’ case study | Has the number of patients you normally treat changed?  
Have the types of patient you normally treat changed?  
Are they patients staying longer/shorter (length of stay) in hospital? |
| Has the patient information changed? | Has the way that you collect information about your patients changed?  
Are we coding the information properly? When was our last coding audit?  
Has the way that you report information about your patients to the DHHS changed? |
| If the patients and patient information haven’t changed, where are we going wrong? | Are we coding the information properly? When was our last coding audit?  
What can we do to get back to our ABF target?  
Can we manage this or should we speak to the DHHS?  
Is there a problem with the DRGs or funding model?  
Does the revenue we can recognise make sense? |
| Specific questions to ask  
Health service is not meeting ABF targets | Are we treating enough patients? If not, why not?  
Have we had a lot of staff absences that is impacting service delivery?  
Could we partner with another hospital who have patients waiting for treatment? |
| Health service is exceeding projected ABF targets and spending more than anticipated | Are we seeing more patients than expected? Why is that? (E.g. has there been a seasonal flu epidemic or major emergency department event).  
Are there safe ways to treat patients without needing to have them stay in hospital? |

*Table 5 - Questions to ask to tease out issues relating to unmet WIES targets (Source: Victorian Government)*
Block funding

ABF is not practical in all health provision circumstances, as discussed above. Additionally, it is not appropriate for all health services and some are better funded through block grants, for example some services in rural and regional communities.

Block funding example - Acute specialist services: Emergency departments

In Victoria, 39 hospitals are funded to provide 24-hour emergency services. Patients who attend these emergency departments can either be admitted to hospital or may be discharged after they receive care in the emergency department. The funding approach for emergency department activity mirrors this patient flow through two streams of funding.

- **NAESG:** Funding for patients who are not admitted, but who receive care in the emergency department only, is provided via the Non-Admitted Emergency Services Grant (NAESG). The NAESG comprises two parts: an availability component and an activity component.
- **Funding for activity that occurs in the emergency department for patients who are subsequently then admitted as inpatients is provided through the inpatient price, which is WIES.**

In 2015–16 the department commenced reforms to better align the non-admitted and admitted acute funding pools to reflect the activity being reported. This shift saw some funds being transferred from the NAESG into the admitted funding mechanism.

In 2017–18, DHHS will continue with this funding reform and maintain this split funding approach for the different patient pathways (admitted or non-admitted). Improving the specificity of the two funding streams will provide a clearer signal to health services about the efficient level of resources required for admitted and non-admitted emergency care.

In addition to improving the alignment between cost and funding for non-admitted emergency care, DHHS has used different measures to allocate the availability and activity component of the funding. The funding model design will retain the two components.

Another block funding example - SRHS funding model

The block funding model applies to SRHS that meet the IHPA criteria for block funding.

The IHPA criteria is used to determine which public hospital services are eligible for block funding. Block funding can apply when:

- it is not technically possible to use ABF
- there is an absence of economies of scale that means some services would not be financially viable under ABF.

Case study – SRHS funding

An elderly gentleman with a chronic medical condition attends the urgent care centre where he is assessed by the general practitioner on call, who assesses and treats the patient before sending him home.

The GP costs for this episode are funded through the Medical Benefits Scheme. The other costs involved in running the urgent care centre are funded through the small rural flexible funding model.

To support this patient in his home, the urgent care centre provides a number of non-admitted services, for example, district nursing and allied health assessment and support.

These services are funded through the small rural flexible funding model.

Despite this, the patient’s condition deteriorates and he is admitted as an acute inpatient.

**This episode is also funded through the small rural flexible funding model.**

After an extended admission it is decided that the patient’s underlying health status has deteriorated and he is no longer able to live at home. He is assessed as eligible for residential aged care and moves into the nursing home wing of the hospital.

**Funding for his care is now through the aged care funding system.**
Eligible facilities in scope for block funding are Local Hospital Networks that meet the block funding criteria.

The Victorian Government is required to provide advice to the IHPA on which hospitals meet the block funding criteria on an annual basis. For SRHS, this advice can be provided once every six years, or more frequently at the discretion of the government.

The Victorian SRHS funding model allows the hospital to use funding flexibly according to the needs of the community. Funds can be used to provide the optimum mix of admitted and community based care. For more information, please visit: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding/abf-services-streams/small-rural-services

Other funding types

Some types of funding are block funded rather than ABF for other reasons, such as the complexity of developing a DRG type system for those services. Examples of this include mental health treatment and aged care.

Mental Health Funding

The IHPA has priced admitted mental health services using DRGs as the classification system, however, the pricing authority has determined that non-admitted mental healthcare will be block funded until such time as the new mental healthcare classification is available.

IHPA is currently developing a new classification system for mental health services. Overall mental health budgets for each health service across both admitted and community settings will be maintained during this transition period to the ABF model.

Dental Health

The Dental Health Program provides public dental care to eligible Victorians.

The Department of Health & Human Services funds Dental Health Services Victoria (DHSV) to deliver both routine and urgent dental care. Services are delivered through the Royal Dental Hospital Melbourne and 79 clinics across Victoria, operated by community health and rural public health services.

Providers of public dental care are guided by Department of Health & Human Services policies and guidelines on eligibility, priority of access, public dental fees, the dental waiting list, and data reporting.

Aged Care Services

For some health services, the provision of aged care services will be the primary form of service provided. The SRHS case study also touches on this.

The aged care system caters for Australians aged 65 and over (and Indigenous Australians aged 50 and over) who can no longer live without support in their own home. Care is provided in people’s homes, in the community and in residential aged care facilities (nursing homes) by a wide variety of providers.

The Commonwealth is the primary funder and regulator of the aged care system. Total government expenditure on aged care services was around $15.8 billion in 2014–15, with the Commonwealth providing approximately 95 per cent of this funding.

The Aged Care Act 1997 (Cth) and associated Aged Care Principles set out the legislative framework for the funding and regulation of aged care, although services are also provided through contractual arrangements outside of this Act. The Department of Health is responsible for the operation of this Act.

The Victorian Government also contributes funding and support for public sector residential aged care services (PSRACS).

There are over 180 PSRACS throughout Victoria, making the Victorian Government the largest public provider of

146 For more information, please visit: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding/abf-services-streams/small-rural-services

residential aged care in Australia. Most services are operated by public health services, in rural and regional Victoria. This helps older people to access residential aged care within their local community.

PSRACs have an important role in providing care to older people with more complex, specialised care needs. Victoria is the only provider of aged persons’ mental health services that specialise in caring for older people with a mental illness and/or persistent cognitive, emotional or behavioural issues.

DHHS contributes funding for PSRACs to support:

- the viability of SRHS
- residents with specialised care needs
- a skilled and qualified nursing workforce.

The Victorian PFG explains DHHS’ process and unit-priced funding approach for PSRACs.

A service planning and development framework has also been developed to help PSRACs to develop services that meet the needs and expectations of their local communities.

Accrual accounting – How health services are funded for service provision

Accrual accounting refers to the approach of accounting where financial transactions are recognised in their relevant accounting period, (i.e. the point in time when the services are delivered), whereas the associated cash flows can occur at different times (i.e. the point in time when the services need to be paid for).

Consideration for the timing differences of cash flow need to be understood.

Directors and the board should seek information from their executive on any financial implications arising from accrual accounting.

Cash Flow Forecasts & Financial Sustainability Issues

Boards should receive regular cash flow reports from their management group that also forecast the cash position of the health service to the end of the financial year. This encourages active consideration of financial sustainability and helps to identify cash issues as soon as possible.

In the event a health service is anticipating or experiencing financial difficulties, the health service should contact DHHS as soon as they become aware of this. While DHHS will typically work to facilitate health services in managing their own cash and other financial issues independently, DHHS will also help to provide direct financial support in exceptional circumstances (see the case study ‘financial sustainability’).

Case study – Accrual accounting

From 01 March 2015 to 30 June 2015, Better Care Service recognised expenditure for electricity of $10,000 each month, a total of $30,000. They did not receive an actual invoice until 30 June 2015.

Even though expenditure of $30,000 was recognised, no cash had been paid against the invoice. The terms of payment on the invoice give the health service 14 days to pay the full value, which means Better Care Service will actually pay for the electricity in July, however, expenses have been recognised for each of the 3 months from 01 March to 30 June.

The health service has a mismatch between the expenditure they see in their accounting system and the cash they have paid as at 30 June.
There are instances when events occur that cannot be anticipated, for example malfunctioning equipment that cannot be easily predicted and can have significant cash implications. DHHS may consider these types of events however, there is an expectation the health service is adequately maintaining equipment and infrastructure, and creating cash provisions for eventual replacement.

Case study: Financial sustainability

The board of Better Care Service (BCS) holds its board meeting in the first week of each month. In anticipation of the February meeting, the CFO finalises the January accounts and prepares updated financial reports for the board to review.

In the February meeting, the board asked the CFO to present the health services current financial position. The CFO reported that a financial risk had been identified - BCS was experiencing higher salary and wage costs than budgeted for. The reason for this was due to the recent departure of several long standing nursing staff, for which BCS was struggling to find full time replacements. As such, they were relying on agency staff, which cost more than full time staff equivalents.

The implication of this in the short term was costs were higher than the revenue they were receiving, with cash reserves continuing to reduce until the vacant positions could be filled. Given the current skills shortage in the region, it was unlikely BCS would be able to recruit new staff against these positions for at least another 2 months.

This was placing stress on BCS’s financial operating outcomes and available cash with the CFO forecasting BCS would deplete its current cash reserves within 3 months. After this point, BCS will be forced to delay payments to some creditors; prioritising financial obligations to pay current hospital staff and critical medical supplies.

Following the presentation, the CFO recommends BCS seek additional funding support from DHHS. The board votes and unanimously agrees with the CFO’s recommendations. The board directs the CFO to formally correspond with DHHS highlighting the financial risk identified.

The CFO writes to DHHS outlining BCS’s current financial situation, the CFO’s analysis of the factors affecting BCS’s cost overrun and a request for financial support should they not be able to recruit new full time staff within the next 2 months. In order to expedite the matter, the CFO calls the relevant executive at DHHS.

<table>
<thead>
<tr>
<th>Health service steps</th>
<th>DHHS steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial issue/risk identified</td>
<td>During this review process, the DHHS will regularly engage the health service to discuss and the financial issue/risk.</td>
</tr>
<tr>
<td>Formal correspondence sent to the DHHS requesting assistance with the financial issue/risk</td>
<td>The DHHS will analyse and review the financial issue/risk.</td>
</tr>
<tr>
<td>Detailed analysis of the financial issue/risk should be provided to the DHHS when making the request</td>
<td>Following consideration of the financial issue/risk, the DHHS will communicate the appropriate category of support it will provide to the health service.</td>
</tr>
</tbody>
</table>

*Figure 13-1 Funds request flow chart (Source: Victorian Government)*
As you can see from the case study ‘financial sustainability’, accrual accounting can impact many transactions, such as payment of salary and wages. In practice, this can create problems where a health service may appear to have more cash available than anticipated.

The funds request flow chart above (Figure 13.1) highlights the latter points raised in the case study ‘financial sustainability’ and what a health service should do when it has identified a financial issue/risk.

Financial governance framework

Each health service is accountable to the Minister for its own financial management and reporting on the resources it uses. Financial governance is an important responsibility for all directors of a health service board. All health services have accountabilities under various legislation including the FMA and the Audit Act.

The FMA sets the financial management accountability, reporting and financial administration obligations of the Government and the Victorian public sector. The diagram below sets out the financial management framework hierarchy.148

[Diagram of financial management framework hierarchy]

The financial governance framework is essentially a number of elements that assist a health service board in ensuring its health service is financially viable. The elements are discussed below.

The role of the board is to steer the health service on behalf of the Minister in accordance with Victorian Government policy and consequently the board is accountable to the Minister for achieving the financial targets agreed in its annual SoP (or other service agreement established with the Government), in line with the requirements of the Enabling Acts and other statutes.

Financial governance underpins the viability of a health service and directors’ responsibilities in this regard are outlined not only in the Enabling Acts but also by broader obligations established by the Victorian Government for the management of public monies.

There are four main elements to financial governance:

Specific obligations under the relevant Enabling Act - outlines that health services are accountable to the Minister for achieving the financial targets agreed in its annual SoP or service agreement established with the Government

Obligations outlined in the FMA - Accounting and reporting policy and processes applicable to all public sector entities

Standing Directions from the Minister for Finance – additional high-level procedures applicable to health services to enable agencies to tailor arrangements to suit their circumstances

Audits by the Auditor General – independent review of financial reports and processes to provide Parliament and the public with assurance that the financial information contained in the financial statements of public sector entities is presented fairly and in accordance with the relevant accounting standards.

In the Victorian health system, directors are also required to understand their accountabilities and obligations set out in the SoP (or equivalent service agreement with DHHS) and the PFG. We discuss the four main elements in detail below.

Enabling Acts (including the FMA)

Health services are required to meet specific financial obligations under the Enabling Acts. The key responsibilities of the board under the Enabling Act and other relevant legislation (e.g. the FMA) include:

- achieving financial targets agreed in the SoP (or other service agreement)
- monitoring financial performance
- ensuring the health service is financially viable
- establishing an audit and finance committee
- preparing an annual report of operations and financial statements.

Financial Management Act – specific requirements

The FMA provides the basis of preparation of financial reports for health services. It details the accounting standards that must be applied to internal management accounts and reflected in the health service’s annual report (public) and key content that must be disclosed. DTF administers the FMA and provides guidance to board directors regarding the format and content of financial reports.

Specific requirements of the FMA that health service boards and management must be aware of, include:

- maintaining a register of assets
- keeping proper accounts and records of financial transactions
- provide the Minister for Finance with any information as requested
- preparing an annual report of operations and financial statements.

Standing Directions of the Minister for Finance

The Minister for Finance issues standing directions to health services to enable tailoring of the broader public sector financial policies and processes to suit individual health service circumstances. The Standing Directions and other related material, are available from the DTF website. The Standing Directions are updated each year and include directions such as:

- financial management governance and oversight, including requirements to implement and maintain a financial code of practice and establish an audit committee

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149 Available from: www.dtf.vic.gov.au. Please note, new standing directions are published every year. When reviewing this guide please refer to the latest standing directions.

150 Available from: www.dtf.vic.gov.au
• financial management structure, systems, policies and procedures
• financial management reporting, including information to be included in the annual report required under the FMA.

Audits by the Victorian Auditor-General’s Office (VAGO)

Under the Audit Act, the Victorian Auditor-General’s Office (VAGO) conducts financial statement audits of public sector entities every year. The purpose of the audits is to provide assurance that the reported financial information is accurate and prepared in accordance with the relevant accounting standard and policies applicable to Victorian public sector entities.

Boards should also be aware that health services are required to prepare and account their financial data in accordance with the Australian Accounting Standards (AAS). The AAS set the framework for which transactions, financial elements and processes should be recognised, recorded and reported. This is particularly pertinent to the annual financial report that is required to be prepared following the end of each financial year and is subject to auditing by VAGO.

Audits of health services accounting, record keeping, processes and reporting are undertaken directly by VAGO or a VAGO representative. Health services are required to ensure that these are done in accordance with the AAS framework. The annual report must be prepared to meet the minimum requirements of the AAS and auditors will issue a statement as to whether or not the health services accounts have met these standards.

Compliance with the Audit Act requires the health service to allow these audits to take place, i.e. that all the information is provided and that relevant staff are available to answer questions and provide any necessary documentation. Other elements of compliance with the Audit Act include:
• the board’s audit and risk management committee and the health service’s internal auditors maintain a constructive relationship with VAGO
• the health service administers a well-targeted program of internal financial and compliance audits so there are no surprises when VAGO conducts an audit.

The role of the board in financial governance

As discussed briefly above, the board has ultimate responsibility for the monitoring and oversight of financial performance of a health service. The Enabling Act outlines the key responsibilities of boards with respect to financial governance and these include:
• the development of financial and business plans, strategies and budgets to ensure the accountable and efficient provision of healthcare services and the long-term financial viability of the health service
• monitoring the performance of the health service to ensure it operates within budget, and its audit and accounting systems accurately reflect the financial position and viability of the health service.

Together, boards and management are responsible and accountable for ensuring the systems and processes are in place to comply with the financial governance framework (the four categories listed above), with the board responsible for setting the financial parameters, accounting policies, KPIs, targets and objectives through the development of the SoP.

Management are responsible for implementing these policies and preparing the relevant financial information and reports for board review.
• In practice, the board’s role in financial governance requires directors to:
• have a good working knowledge of the financial governance framework and its requirements
• understand the funding mechanisms that support the health service (both clinical and operational)
• have a basic level of financial literacy and understanding of key financial performance metrics for a health service

understand the links between financial performance and the provision of clinical care services, risk management and strategy development.

Financial performance reporting

There is a range of financial reports that boards of health services should regularly monitor. The board should ensure they, or the audit committee, receive regular financial management and performance reports. Table 6 below provides an example of standing items that could be reported directly to boards or through board committees.

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<thead>
<tr>
<th>Activity</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<td>Vic Health Incident Management Report</td>
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<td>CEO/CFO Report (balanced score card)</td>
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<td>Financial Operating Results</td>
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<td>Finance Committee reports</td>
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Table 6 Annual reporting activities throughout the year: the blue highlighted boxes show when the activity is relevant during the year. Rows highlighted in blue show the activity will be relevant in all months of the year

Directors’ duties

There are many ways that financial information can be presented, and sometimes this information can be complex. Boards must be comfortable with the reports it receives in order to effectively fulfil its duty to ensure the financial viability of the health service. Each director has a duty to ensure the financial management of the health service meets the required standards, therefore, a lack of financial literacy or understanding does not justify or absolve any director of their responsibilities.

In practice this involves actively understanding the clinical environment in which the health service operates; the services it provides; how they are provided; the quality and safety standards that must be adhered to and the compliance and administrative frameworks (within the health service and within DHHS) to which the organisation must align.

Reading and interpreting financial reports

Boards must review and interpret financial and clinical data on a regular basis. A range of reports will need to be tabled at board meetings at regular intervals throughout the year. The board’s annual agenda (refer to Appendix 6) should outline what is to be reviewed and when, so that nothing is missed.

Refer to Chapter 14 – Understanding data for more information about reading and interpreting financial reports.
Useful references

- Kayser-Bril, Nicolas, *Become Data Literate in 3 Simple Steps*, from Journalism++, published online in the Data Journalism Handbook (1.0 beta): http://datajournalismhandbook.org/1.0/en/understanding_data_0.html
- Doig, Steven, *Basic steps in working with data*, from xx, published online in the Data Journalism Handbook (1.0 beta): http://datajournalismhandbook.org/1.0/en/understanding_data_2.html
14. Understanding data

Huge amounts of data are generated by, and for, health services – all with unique and important purposes. Being able to identify risks and manage performance in line with Ministerial and public expectations requires all directors to have a working understanding of how to interpret clinical, financial and operational data. It also requires boards and directors to know what the data/performance metrics are, why they are important and how to assess and challenge the information presented to them, as well as be able to recognise red flags on any weaknesses, and identify strengths that can form the basis of improvements for other health services.

Questions that directors of health services should ask

- Am I comfortable that I understand all the data and information presented by management at board meetings?
- What does good performance really look like?
- What are the key performance targets or service levels that we are aiming for? What is the relevance of the metrics to our service?
- How are we tracking against where we think we should be?
- What information is management presenting and is it telling us what we need to know in order to be able to effectively measure performance against our strategic objectives?
- Am I satisfied with the explanation for any variances? Has management provided me with enough information to understand the reason for a good/poor outcome? Do I understand how good outcomes relate to other aspects of health service governance (e.g. DHHS funding, monitoring)?
- Is the variance good/favourable or bad/unfavourable (noting that an increase in one measure can be good or bad depending on the measure)?
- What trends are we seeing in our performance and do we know what actions (if any) we need to take in response?
- How does the performance of our health service compare to that of our peers? Who could we compare ourselves to in order to benchmark and/or better understand our performance?152
- What are the implication of poor performance with respect to DHHS’ performance monitoring framework?
- What additional information might we need to gain the best insight into our performance?
- Am I confident in my own ability to understand and interpret the data presented?
- Does the board regularly engage with specialists (clinicians, accountants, auditors, DHHS) to better detect and understand issues?
- Are the data reporting systems operating effectively such that the data being reported is accurate, timely and complete? How do I know this with confidence?
- When was the last time the board saw source data (e.g. bank statements)?

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Red flags

- Data and reports regarding key clinical, financial and operational metrics are not questioned by the board.
- Some directors do not contribute to the discussion about financial or clinical performance because they don’t feel as qualified as others on the board.
- Staff/workplace culture issues are not recognised as risks to clinical safety (for example, low response rates to staff surveys and/or poor rates of agreement with safety culture questions in the People Matter Survey).
- There are no board directors with clinical practice or financial skills on the board.
- Variance and trends in clinical, financial or operational performance data is not discussed or questioned by directors.
- Performance reports are provided in an ad hoc manner and/or inconsistent format.
- The majority of the board’s directors leave questioning of clinical or financial performance data to the 1-2 clinicians or accountants on the board.
- Directors are unable to articulate the top clinical, financial and operational risks faced by their health service.
- No benchmarking of health service performance is undertaken.
- Directors jump to conclusions about what the data is a symptom of, rather than seeking counsel from management.

Introduction to the chapter

This chapter considers the role of directors and boards when it comes to understanding both financial and non-financial data. Clinical data is often complex and full of acronyms and concepts that are unfamiliar to most directors. Directors must possess two key qualities – curiosity and healthy scepticism - in order to gain the level of assurance they need to fulfil their duties. This chapter outlines some of the different types of data and the key things to look for when reviewing the multiple sources of information.

Health service data

Data underpins many important decisions. It not only tells a story about performance, it is used to develop future performance targets and strategic objectives.

Like many organisations, there are huge volumes of data available for health services to understand and interpret. This is not an easy task, but it is imperative to get it right. Often it is difficult to determine what information is most relevant (and why), what the key characteristics of the data are and how a board can really extract the most value from the vast amount of information available to it.

For boards to be able to fulfil their governance responsibilities, health service data must be:

- presented in a timely manner
- relevant to the strategic objectives and performance targets agreed in the SoP
- accurate and provide a complete picture, with no omissions.

The importance of health services providing and having access to quality data is recognised by DHHS with the establishment of a Victorian Agency for Health Information (VAHI) that is tasked with analysing and sharing information across the health system. Through its activities, the agency will provide transparent and accurate information regarding the strengths and weaknesses of the entire Victorian health system.
Types of data

Data is provided across all areas of a health service and is predominantly in two forms:

- **Quantitative** – data involving quantities such as operational data (number of admissions and readmissions, stock numbers), clinical data (clinical outcomes, infection rates) safety measures (lost time injuries), workforce data (turnover rates, employee engagement) and financial costs. Quantitative data is often easier to compare over time, providing a standard and discrete unit of measure on which percentages, growth rates, variances and trends can be calculated.

- **Qualitative** – data that is more subjective and descriptive or narrative in nature. This type of data is often harder to ‘measure’ in discrete forms. Qualitative data may look like survey comments, complaints and opinions. It involves measures of an individual’s perception of service.

Both are as equally important, but require different analytical skills.

Analysis of data

Each organisation should have a suite of analytical tools to assist them in analysing and assessing the performance data they collect internally. The tools used will vary depending on the systems used, the data collected and the level of data collection and reporting maturity within each organisation.

Partial analysis, including the calculation of relevant metrics and performance ratios, should always be prepared by management, together with management’s commentary regarding anomalies, trends and progress against KPIs.

Boards should not be getting raw data.\(^{153}\)

If this is happening, it indicates two things:

- management may not have sufficient systems or processes in place for collating data or using it to monitor performance on a daily basis. This is a warning sign that operational issues requiring ongoing attention (i.e. not just monthly reporting to the board) are not being monitored. Significant operational, financial or clinical issues could be occurring.

- the board is unable to articulate to management the information it needs to ensure it is meeting its obligations under the Enabling Acts. If boards are receiving raw data, they are:
  - delving into operational issues that are the remit of management
  - not appropriately aware of the information they need to effectively oversee the performance of the health service.

Examples of analytical tools that Victorian health services use, include tailored spreadsheets or data base analysis tools (e.g. Microsoft Access).

Tailored solutions including spreadsheets and internally developed databases should be routinely subject to independent assurance to verify the accuracy of the data collection, calculation and reporting processes.

Assurance

In a governance context, assurance is critical. It is about assuring yourself, as a director, that you have the right and relevant information so you (individually and collectively as a board) can make informed and better decisions.

Directors have an obligation to assure themselves their health service is providing safe, effective person-centred care and is meeting all the other financial and operational performance measures set out by DHHS. Directors individually, and the board collectively, must be able to satisfy themselves the information provided by management is

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\(^{153}\) There are of course exceptions to this, such as seeing source data to provide confidence. For example, it is necessary to occasionally seek and be provided actual bank statements to provide assurance that the cash that ought to be there is.
accurate and relevant to support and inform effective decision-making.

They key steps in understanding data and obtaining assurance over information reported to the board are detailed in Error! Reference source not found.

Armed with curiosity and healthy scepticism, directors must detect, respond and monitor the information provided to them and seek to validate or test this information with other sources.

**Detect**

**Detection** requires that directors:

- actively consider the information provided to them and not simply defer to the director with expertise in this area
- understand the information presented
- understand the information within its context
  - why a change occurred?
  - is this outcome/trend is good or bad? Compared to what (e.g. risk threshold) / whom (e.g. performance of services that are a similar size) / when (e.g. prior year performance)?
- consider the explanations/commentary given regarding any variances
  - is the explanation is sufficient?
    - consider the size of the variance in context not every variance will warrant commentary. For example a variance of $50 in a budget line of $5 million is not worth commentary. However, if that variance was $2 million, that would definitely warrant an explanation.
- ask questions, particularly where there is a variance in data presented that is not accompanied with an adequate explanation
• access multiple sources of information that will validate or challenge the information presented (for example: the Monitor, AIHW reports, health services performance website)
• not rely on others to ask questions or drive discussions, each director is individually accountable
• ensure that management provide board reports that only include relevant information.

Respond

Once a performance issue has been identified, it is the responsibility of management – not the board - to determine the appropriate response i.e. boards must not delve into operations and try to implement a solution. Instead, they must:
• assign responsibility to management to address the issue
• understand the types of management responses that are available (i.e. changes to a process or systems, engaging consultants, undertaking audits)
• develop appropriate accountabilities so that you can see progress is being made (KPIs, patient stories, case reviews).

Monitor

Monitoring the effectiveness of the response requires boards to:
• understand how they expect the data to improve (metrics to monitor, trends to look for)
• benchmarking their ongoing performance against peers
• obtain information from other sources (not just from the CEO) in order to make an assessment of the effectiveness of the management controls in place.

Information sources

There are many sources of external and internal information that directors can draw on as outlined in Table 7 below.

<table>
<thead>
<tr>
<th>Externally available information</th>
<th>Within your own health service</th>
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<tbody>
<tr>
<td>Public inquiries (e.g. VAGO, reviews such as Targeting Zero)</td>
<td>Clinical reports.</td>
</tr>
<tr>
<td>Networking events.</td>
<td>Staff surveys.</td>
</tr>
<tr>
<td>Engagement with/information from agencies – SCV, DHHS, VAHI, VMIA.</td>
<td>Walk-arounds to observe culture, processes, the condition of assets etc.</td>
</tr>
<tr>
<td>Newspapers and media.</td>
<td>Patient experience questionnaires/stories.</td>
</tr>
<tr>
<td>Peers and benchmarks.</td>
<td>Board and committee reports and minutes.</td>
</tr>
<tr>
<td></td>
<td>Internal audit report</td>
</tr>
</tbody>
</table>

Table 7 – Information sources for directors to source as part of the assurance process

Data integrity

DHHS maintains a health data audit program of all health services reporting to the department’s key datasets. Health service boards are accountable for the accuracy of data on which their health service reports (via board audit committees), and must regularly conduct internal audits. In addition health service boards are required to provide a statement in their annual report to Parliament that they have appropriate systems and processes in place to assure the quality of reported data.

In addition:
• all health service staff using emergency department (ED) and elective surgery waiting list systems are to have a unique identifier and password to access the systems
• changes to specific data fields in health service systems are to be authorised by senior staff
• audit logs are to be maintained of all transactions in these systems for specified data fields

DHHS is also responsible for receiving complaints and investigating complaints concerning manipulation and/or falsification of public hospital data.

The board’s role is to ensure that these requirements are being met through having appropriate policies in place, ensuring that management are implementing the measures in accordance with the policies, and that the assurance processes are in place to monitor how well the controls are working.

The role of committees in understanding data

For more critical areas of focus, like clinical and financial data, boards are required to establish committees to investigate and understand key metrics, trends and benchmarking results that are then taken back to the board for any recommendations and decisions regarding issues that might require action – i.e. systemic issues that need to be addressed, anomalies that cannot be explained or specific incidents that need to be escalated for more immediate action.

Committees can have representation of subject matter specialists to provide advice and guidance on matters under review.

As noted earlier, use of committee does not absolve the board of responsibility when it comes to performance or decision-making. Committees do not make decisions, rather, they make recommendations to the board based on more detailed analysis of the information and issues.

Involvement in committees can provide a valuable ground for a director to improve their understanding of certain issues. A perception that you are not ‘qualified’ for a committee position, may in fact be unwarranted for a director proactively seeking to improve his/her skills and knowledge in a particular area. The committee must have sufficient expertise to be able to advise the board but that does not have to mean that every member has the requisite qualifications. For example, the quality and safety committee should have a clinician that understands clinical governance but ought to also have a non-clinician on the committee.

Board responsibilities

A safe board does more than review the data presented to it by management. Whilst tracking key metrics is important, a safe board does more than sight the reports. Instead, a safe board questions this data, interprets the trends and applies the analysis to strategic review, risk management and stakeholder engagement activities.

As the body charged with oversight and monitoring, accountable to the Minister and the public, it is the board’s responsibility to:

• ensure that the information and reporting systems are in place to capture accurate, timely and complete data
• understand the operating context of the health service and the key data measures that need monitoring to ensure the ongoing viability of the service i.e. the provision of safe, quality health care; financial sustainability; productive and engaged workforce and meeting the needs of the community
• provide management with appropriate guidance regarding the metrics and reports that the board needs to be able to effectively fulfil its duties
• access and utilise all external resources available (including Monitor, VAHI reports etc) to benchmark performance against others in the State, with the intention of identifying improvement and knowledge sharing opportunities that support improvements in the broader Victorian health system
• understand DHHS’ performance monitoring process, including the implications on the operation and reputation of the health service
• engage and include suitable qualified specialists (such as clinicians and or accountants) to provide relevant guidance and assist with the interpretation of data.
Individual director responsibilities

- Each director has a responsibility to ensure that they:
- are appropriately skilled to review and understand financial, clinical and operational data in the context of the broader policy, strategic and health service objectives
- ask questions when they don’t understand or when information presented to them doesn’t make sense
- read all board papers prior to the meeting, coming armed with questions, rather than relying on management to explain the data during the board meeting
- challenge the information provided and questions its relevance. Sometimes management provide too much data – either because they are unsure about what is important to the board, or because they are potentially trying to redirect the board’s attention from performance issues
- commit to ongoing education and learning in areas where they – or others – identify skill gaps in their ability to understand and interpret health service data.
Useful references

- American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSMV or DSM–5) website: https://www.psychiatry.org/psychiatrists/practice/dsm
- Stepnick, Larry, Maximizing the Effectiveness of the Board’s Quality Committee: Leading Practices and Lessons Learned, (Fall 2015), The Governance Institute (White Paper).
- The International Federation of Accountants (IFAC), Information and Communications Technology Literature Review, (Feb 2018). Available from IFAC here: https://www.ifac.org/publications-resources/information-


Appendix 1: List of hospitals and health services

Public Health Services
Albury Wodonga Health
Alfred Health
Austin Health
Ballarat Health Services
Barwon Health
Bendigo Health Care Group
Dental Health Services Victoria
Eastern Health
Goulburn Valley Health
Latrobe Regional Hospital
Melbourne Health
Monash Health
Northern Health
Peninsula Health
Peter MacCallum Cancer Institute
The Royal Children’s Hospital
The Royal Victorian Eye and Ear Hospital
The Royal Women’s Hospital
Western Health

Denominational health services
St Vincent’s Health
Mercy Health and Aged Care
Calvary Health Care Bethlehem

Public hospitals
Alexandra District Health
Bairnsdale Regional Health Service
Bass Coast Health
Beaufort and Skipton Health
Beechworth Health Service
Benalla Health
Boort District Health
Casterton Memorial Hospital
Castlemaine Health
Central Gippsland Health Service
Cobram District Health
Cohuna District Hospital
Colac Area Health
Djerriwarrh Health Services
East Grampians Health Service
East Wimmera Health Service
Echuca Regional Health
Edenhope and District Memorial Hospital
Gippsland Southern Health Service
Heathcote Health
Hepburn Health Service
Hesse Rural Health Service
Heywood Rural Health
Inglewood and Districts Health Services
Kerang District Health
Kilmore and District Hospital
Kooweerup Regional Health Service
Kyabram and District Health Services
Kyneton District Health Service
Lorne Community Hospital
Maldon Hospital
Mansfield District Hospital
Maryborough District Health Service
Moyne Health Services
Nathalia District Hospital
Northeast Health Wangaratta
Numurkah and District Health Service
Omeo District Health
Portland District Health
Rochester and Elmore District Health Service
Rural Northwest Health
Seymour Health
South Gippsland Hospital
South West Healthcare
Stawell Regional Health
Swan Hill District Health
Tallangatta Health Service
Terang and Mortlake Health Service
West Gippsland Healthcare Group
West Wimmera Health Service
Western District Health Service
Wimmera Health Care Group
Yarram and District Health Service
Yarrawonga Health
Yea and District Memorial Hospital

**Multi purpose services**
Alpine Health
Corryong Health
Orbost Regional Health
Otway Health
Mallee Track Health and Community Service
Robinvale District Health Service
Timboon and District Healthcare Service

**Early Parenting Centres**
The Queen Elizabeth Centre
Tweedle Child and Family Health Service

**State-wide services**
Ambulance Victoria
Health Purchasing Victoria
Victorian Institute of Forensic Mental Health
## Appendix 2: Key provisions of each Enabling Act

<table>
<thead>
<tr>
<th>Governance provision</th>
<th>HSA</th>
<th>ASA</th>
<th>MHA</th>
<th>VIFMH</th>
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<tbody>
<tr>
<td><strong>Public hospital</strong></td>
<td>Sect 65S(1)</td>
<td>Sect 115E(1)</td>
<td>Sect 17(1)</td>
<td>Sect 332</td>
</tr>
<tr>
<td><strong>Public Health service</strong></td>
<td>Sect 65S(2)</td>
<td>Sect 115E(2)</td>
<td>Sect 18(1)</td>
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<tr>
<td><strong>Multi-purpose service</strong></td>
<td>Sect 65S(3)</td>
<td>Sect 115E(3)</td>
<td>Sect 18(2), 18(3)</td>
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<tr>
<td><strong>Ambulance</strong></td>
<td>Sect 17(1A)</td>
<td>Sect 17(2)</td>
<td>Sect 17(2)</td>
<td>Sect 335</td>
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### Board composition

<table>
<thead>
<tr>
<th>Number of board directors</th>
<th>Sect 33(3)</th>
<th>Sect 65T(2), 65T(3) and 65T(4)</th>
<th>Sect 115E(4)</th>
<th>Sect 17(1A)</th>
<th>Sect 333</th>
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<tbody>
<tr>
<td>Not less than 6 and not more than 12</td>
<td>Not less than 6 and not more than 9</td>
<td>Not less than 6 and not more than 9</td>
<td>Not less than 6 and not more than 9</td>
<td>Not less than 4 and not more than 7</td>
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</table>

| Board appointments and composition | Sect 33(5), 33(6), 33(7), 33(8), 33(9), 33(10) | Sect 65U | Sect 115F | | Sect 334 |
|------------------------------------|---------------------------------|-----------|------------|--------|
| Terms and conditions of appointment | Sect 34 | Sect 65U | Sect 115F | | Sect 335 |
| 3 year terms, eligible for reappointment | 3 year terms, eligible for reappointment for a maximum period of 9 years | 3 year terms, eligible for reappointment | 3 year terms, eligible for reappointment for a maximum period of 9 years | |

| Removal and resignation | Sect 35 | Sect 65V | Sect 115G | | Sect 336 |

### Board procedures

<table>
<thead>
<tr>
<th>Annual meetings</th>
<th>Sect 36</th>
<th>Sect 65ZG</th>
<th>Sect 115H</th>
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<tbody>
<tr>
<td>Procedure of board</td>
<td>Sect 37</td>
<td>Sect 65X</td>
<td>Sect 115I</td>
<td>Sect 19</td>
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<tr>
<td>Governance provision</td>
<td>HSA</td>
<td>ASA</td>
<td>MHA</td>
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<tr>
<td>Notice of Directions (including Ministerial directions)</td>
<td>Sect 40A, 40B</td>
<td>Sect 66, 66A</td>
<td>Sect 34A, 34B</td>
<td></td>
</tr>
<tr>
<td>Public hospital</td>
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<tr>
<td>Public Health service</td>
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<tr>
<td>Multi-purpose service</td>
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<tr>
<td>Strategic Plans</td>
<td>Sect 65ZF</td>
<td>Sect 65ZFA, 65ZFB</td>
<td>Sect 22E</td>
<td>Sect 343</td>
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<tr>
<td>Statement of Priorities</td>
<td></td>
<td>Sect 22F</td>
<td>Sect 344</td>
<td></td>
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<td>Service agreement</td>
<td>Sect 26</td>
<td></td>
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<tr>
<td><strong>Board renewal</strong></td>
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<tr>
<td>Appointment of delegates to the board</td>
<td>Sect 40C</td>
<td>Sect 65ZAA</td>
<td>Sect 22B</td>
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<tr>
<td>Function of the delegate</td>
<td>Sect 40D</td>
<td>Sect 65ZAB</td>
<td>Sect 22C</td>
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<tr>
<td>Obligations of the board to the delegate</td>
<td>Sect 40E</td>
<td>Sect 65ZAC</td>
<td>Sect 22D</td>
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<tr>
<td>Appointment of administrator</td>
<td>Sect 57A</td>
<td></td>
<td>Sect 115R</td>
<td>Sect 35</td>
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<tr>
<td>Amalgamation</td>
<td></td>
<td></td>
<td>Sect 115T</td>
<td></td>
</tr>
<tr>
<td><strong>DHHS/Minister/GiC Intervention and Approvals</strong></td>
<td></td>
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<tr>
<td>Appointment of Chief Executive Officer (Approval by Secretary)</td>
<td>Sect 65XA</td>
<td>Sect 18</td>
<td>Sect 340</td>
<td></td>
</tr>
<tr>
<td>Financial Accommodation (Approval from Minister and Treasurer)</td>
<td>Sect 30</td>
<td>Sect 30</td>
<td>Sect 30</td>
<td>Sect 44</td>
</tr>
<tr>
<td>Changes to name, objects or alter Its by-laws (Approval from Secretary)</td>
<td></td>
<td></td>
<td>Sect 115N</td>
<td></td>
</tr>
<tr>
<td>Governance provision</td>
<td>HSA</td>
<td>ASA</td>
<td>MHA</td>
<td></td>
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<tr>
<td>-----------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Right of intervention in management (Minister Intervention)</td>
<td>Sect 69F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: Regulatory bodies

The Health Complaints Commissioner

In Victoria, consumers have a right to make complaints about health service providers and to access their health records. The Health Complaints Commissioner (HCC) was established under the Health Complaints Act 2016 (Vic). The HCC’s role is to receive, investigate and resolve complaints from users of health services, to support healthcare services in providing quality healthcare, and to assist them in resolving complaints. The legislation also requires the information gained from complaints be used to improve the standards of healthcare and prevent breaches of these standards.

The HCC also administers the Health Records Act 2001 (Vic), the Victorian legislation dealing with the privacy of health information and an individual’s right to have access to their own information. It handles complaints about disclosure of health information and access to health information. The Freedom of Information Act 1982 (Vic) also allows consumers to access information contained in public sector medical records, and for incorrect or misleading information to be amended or removed from records.

The Australian Information Commissioner may also refer complaints concerning health information privacy issues raised under the Privacy Act 1988 (Cth) to the HCC for resolution.

While a coroner investigates deaths (see later in this section), the HCC is empowered to investigate other matters raised through individual complaints about the services provided by Victoria’s public health services, and to suggest ways of improving services. If a complaint involves the professional conduct or performance of a registered health practitioner, the commissioner liaises with the Australian Health Practitioner Regulation Agency (AHPRA) about its handling and resolution.

The Minister for Health has the power to request the commissioner to conduct independent reviews of health service issues. An example of a report on such a review is the Analysis of the inquiry held by the Health Services Commissioner 2002 into an incident at The Royal Melbourne Hospital, Victoria.


The Mental Health Complaints Commissioner

The Mental Health Complaints Commissioner is an independent, specialist body established under the MHA to safeguard rights, resolve complaints about Victorian public mental health services, and recommend improvements.

Section 228 of the MHA gives the Commissioner the following key functions:

- to accept, assess, manage and investigate complaints relating to public mental health services
- to attempt to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation) as appropriate
- to provide advice on any matter relating to a complaint
- to make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaint procedure
- to provide information, education and advice to services about their responsibilities in managing complaints
- to help consumers and people acting on their behalf, or who have a genuine interest in their wellbeing, to resolve complaints directly with services, either before or after the Commissioner accepts the complaint
- to help services improve policies and procedures to resolve complaints
- to identify, analyse and review quality, safety and other issues arising out of complaints and make recommendations for improvements to services, the Chief Psychiatrist, the Secretary and the Minister
- to investigate and report on any matter relating to services at the request of the Minister.
The MHCC has broad powers to deal with complaints in relation to designated mental health services and publicly funded mental health community support services.

To strengthen oversight, the Act also introduced the requirement for all public mental health services to provide a twice-yearly report to the MHCC detailing the number of complaints they have received and the outcomes of those complaints.


The Ombudsman

The Victorian Ombudsman has the power to investigate administrative actions taken by a Victorian Government department or public statutory body, including public health services. The Ombudsman is a constitutional independent officer of the Victorian Parliament established under the Ombudsman Act 1973, and reports directly to Parliament. The matters investigated by the Ombudsman may arise through individual complaints about administrative actions or through disclosures of serious improper conduct under the Protected Disclosures Act Vic (2012).

An example of a report on such an investigation is the Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations.\(^{154}\)

The office also has a role in ensuring compliance with the Freedom of Information Act and the Charter of Human Rights and Responsibilities Act 2006 (Vic).

Further information is available at www.ombudsman.vic.gov.au

The Auditor-General

The Victorian Auditor-General is an independent officer of the Victorian Parliament appointed under the Audit Act 1994 to examine resource management in the public sector. The Auditor-General is responsible for auditing all public sector organisations, including the department and public health service entities. The independence of the Auditor-General is enshrined in the Constitution Act 1975 (Vic), which establishes the office and gives the Auditor-General complete discretion when deciding whether to conduct an audit, how to carry it out and how to prioritise any particular matters.

Among other things, the Auditor-General is empowered to:

- conduct annual financial statement audits of public sector agencies
- undertake performance audits within the public sector that encompass assessments of the economy, efficiency and effectiveness of the management of public resources by the Government or individual Government agencies
- examine instances of waste, probity or lack of financial prudence in the use of public resources
- access a broad range of documents under section 11 of the Audit Act.

The Auditor-General and staff are able to access all public sector information, irrespective of any restrictions imposed by other legislation, including statutory secrecy provisions and Cabinet or commercial-in-confidence confidentiality.

Financial statement audits provide independent assurances to Parliament and the community that the information contained in the financial statements of public sector entities is presented fairly in accordance with Australian accounting standards and applicable legislation. They are carried out at the end of each financial year.

A performance audit evaluates whether an organisation or Government program is achieving its objectives effectively, economically and efficiently, and in compliance with all relevant legislation. These

are carried out when the Auditor-General considers they are warranted, with the audit program developed in consultation with relevant sectors and agencies. Examples include:

- Board performance (2016);
- Public Hospitals: 2015 – 2016 Audit Snapshot (2016);
- Efficiency and Effectiveness of Hospital Services: High-value Equipment (2015);
- Palliative care (2015);
- Hospital Performance: Length of Stay (2016).


Health services and the department are required to provide a response to the recommendations of performance reviews. Where appropriate the department and health services act to implement changes as recommended by the Auditor-General.

**Coroner**

Coroners investigate unexplained natural deaths and deaths suspected to be from direct or indirect trauma. From time to time, this involves investigating deaths that occur in health services.

The importance of a coronial investigation is that it can lead to a greater understanding of risks and hazards in the community as well as to improvements in public health and safety.

By being empowered to hold a public court hearing (an inquest), coroners have a vehicle for raising in public the facts about how a person died and can use the inquest to raise awareness of how that death could or should have been prevented. In conjunction with the work of a coroner, other statutory agencies including the police, the Chief Medical Officer of Health and the Victorian Institute of Forensic Medicine maintain a constant surveillance on potentially fatal hazards in society and ensure that preventable deaths are recognised and brought to the attention of the relevant public and Government agencies so that the issues surrounding them can be addressed.

**The Aged Care Complaints Investigation Scheme**

Some Victorian public sector health services are approved providers of residential aged care services. While the Commonwealth Government is responsible for planning, funding and regulating residential aged care services, the Victorian Government provides top-up funding to public sector residential aged care services (PSRACS) to assist in providing these services.

The Commonwealth’s *Aged Care Act 1997* (Cth) provides for complaints concerning Commonwealth Government-funded aged care services to be reported to the Aged Care Complaints Investigation Scheme. This scheme is managed by the Office of Aged Care Quality and Compliance, within the Commonwealth Department of Health and Ageing (DoHA). Under the Aged Care Act services are obliged to compulsorily report incidents or allegations of physical and sexual assault of residents and unexplained absences of residents from services to the scheme.

DHHS also requires Victorian PSRACS to notify it of all compulsory reports made to the scheme at the same time or within 24 hours of the service notifying police and the scheme. This parallel reporting requirement ensures the department is informed of all alleged or suspected incidents of physical or sexual assault and unexplained absences of residents from services. The department has developed a report form that contains no resident identifying information. The form is available at [www.health.vic.gov.au/agedcare/services/psracs](http://www.health.vic.gov.au/agedcare/services/psracs). Once the incident has been investigated, outcome details, including copies of correspondence from DoHA and reports, should be provided to the Victorian department.

The Office of the Aged Care Commissioner is an additional mechanism established by the Commonwealth Government to independently review the way in which the complaints scheme handles complaints. Further information about the aged care services complaints process can be found at: [www.agedcarecomplaints.gov.au/](http://www.agedcarecomplaints.gov.au/).
Appendix 4: Board By-Laws (public hospital) example
BY-LAWS

[Note: These By-Laws are subject to formal approval by the Secretary of the Department of Health and Human Services in accordance with the Act]

1. INTRODUCTION

1.1. These By-Laws supersede the existing by-laws of the Health Service. All existing by-laws which were in force prior to these By-Laws coming into operation are hereby repealed and replaced with these By-laws.

1.2. In addition to these By-Laws, the Board makes and maintains other policies and procedures necessary to guide its decision-making process.

2. DEFINITIONS AND INTERPRETATION

2.1. In these By-Laws, unless the context requires otherwise:


2.1.2. “Auditor-General” means the Auditor-General within the meaning of the Audit Act 1994 (Vic) as amended.

2.1.3. "Board" means Board of Management of the Health Service.

2.1.4. “Chair” means the person elected in accordance with these By-Laws to preside over meetings of the Board (however so described).

2.1.5. “Chief Executive Officer” means the Chief executive officer of the Health Service and any person acting in place of such officer.

2.1.6. "Committee" means a Committee established by the Board for the discharge of its business, subject to Board approval.

2.1.7. “Commonwealth” means the Commonwealth of Australia or any Department of the Commonwealth of Australia.
2.1.8. "Department" means the Victorian Department of Health and Human Services and its successors.

2.1.9. “Finance Directions” means the Standing Directions of the Minister for Finance under the Financial Management Act 1994, given under section 8 of the Financial Management Act 1994 (Vic), as amended or replaced from time to time.

2.1.10. “Funding Guidelines” means the most recent Victorian Department of Health and Human Services publication titled Victorian health policy and funding guidelines, as amended or replaced from time to time.

2.1.11. “GSERP” means the Government Sector Executive Remuneration Panel.

2.1.12. “Health Service” means [insert name of Health Service].

2.1.13. “Officer” means an office-bearer of the Health Service elected from amongst the directors of the Board in accordance with these By-Laws, and includes the Chair and any other office-bearers so elected.


2.1.15. “Secretary” means the Secretary to the Department.

2.2. In these By-Laws:

2.2.1. words in the singular include the plural and vice versa;

2.2.2. if a word or phrase is defined to have a particular meaning, the other parts of speech and grammatical forms of that word or phrase have a corresponding meaning;

2.2.3. a reference to a clause is a reference to a clause in these By-Laws; and

2.2.4. a reference to any legislation or a legislative provision includes:
   a) that legislation or legislative provision as amended or replaced from time to time; and
   b) regulations and other instruments made under that legislation or legislative provision.

3. **OBJECTS**

3.1. The objects of the Health Service are:
3.1.1. to operate a public hospital in accordance with the Act, and any enabling Commonwealth or Victorian legislation, including the provision of the following services:

a) public hospital services;

b) primary health services;

c) aged care services; and

d) community health services;[amend/delete as necessary]

3.1.2. to provide a range of high quality health and related services ancillary to those services described in clause 3.1.1;

3.1.3. to carry on any other activity or business that is convenient to carry on in connection with providing the services described in clauses 3.1.1 to 3.1.2, or intended or calculated to make more efficient or profitable any of the Health Service’s assets or activities; and

3.1.4. to do all things that are conducive or incidental to achieving the Health Service’s objects.

4. **BOARD OF MANAGEMENT**

4.1. There will be a Board of Management for the Health Service whose appointment, functions and composition are as prescribed by the Act.

4.2. Subject to the Act and these By-Laws, the procedure of the Board is at the absolute discretion of the Board.

4.3. There will be elected from amongst the directors of the Board a Chair and any other Officers appointed by the Board who will each hold office for a period of one (1) year and be eligible for re-election. If an Officer ceases to hold office, the existing directors of the Board will elect from amongst themselves a member who will hold the office of that Officer until the next election of Officers in accordance with this clause 4.3, and be eligible for re-election at that time.

4.4. Any vacancy or impending vacancy of a member of the Board will be filled in accordance with the Act and any directions or guidelines issued by the Department.

4.5. The Board may make rules and adopt policies and procedures, not inconsistent with the Act and these By-Laws, for the administration of the Health Service.

5. **MEETINGS OF BOARD**

5.1. The Board will meet at least ten (10) times during each year, at such place and at such time as the Board may from time to time determine.
5.2. Special meetings of the Board may be convened by the Chair or any four directors.

5.3. A quorum for a meeting of the Board is not less than half the number of directors appointed and not less than 6 members in total.

5.4. Written notice of each meeting will be served on each member of the Board by delivering it to ensure it arrives with the member, in the case of ordinary meetings, three (3) days, and in the case of special meetings, one (1) day, prior to the meeting being held. Such notice may be delivered by hand, or by post to the usual or last known place of residence or business of the member, or by facsimile or by electronic mail. Failure by any member of the Board to receive due notice of any meeting of the Board will not invalidate the proceedings of that meeting.

5.5. Notice of ordinary meetings must specify the time, date and location of the meeting, and must be accompanied by copies of:

5.5.1. the agenda for the meeting; and

5.5.2. documents or other information relevant to the items on the agenda for the meeting.

5.6. Nothing in clause 5.5 requires that a member of the Board be provided with a document or information if the member has previously been provided with a copy of that document or information.

5.7. Notice of special meetings called in accordance with clause 5.2 must specify the time, date and location of the meeting, and the general nature of the business that is intended to be transacted at the meeting.

5.8. At a special meeting called in accordance with clause 5.2, the only business that will be transacted will be that business specified in the notice of the special meeting.

5.9. All questions arising at any meeting of the Board will be decided by a show of hands or, if demanded by any member, by a division, and voting may be by proxy [ *delete if not applicable]. Each member present will have one vote. The person presiding at a meeting in accordance with clause 5.11 will have a deliberative vote and, in the event of an equality of votes of any question, that person will have a casting vote also.

5.10. No business will be transacted unless a quorum is present and, if within half an hour of the time appointed for the meeting a quorum is not present, the meeting will stand adjourned.

5.11. The Chair will preside at all meetings of the Board, or if the Chair is absent, the person specified as chair in any rules or standing orders made by the Board, or otherwise the directors present will choose one of their number to preside.

5.12. Any member of the Board who has an actual or perceived conflict (including, but not limited to, a direct or indirect material financial and non-financial interest) in any matter brought before the Board for discussion must disclose that interest immediately to the other Board directors and must not be present during discussion on the matter or be entitled to vote upon the matter.
5.13. No resolution of the Board may be varied or rescinded before the expiration of one calendar month after such resolution has been passed, except at a special meeting of the Board called for that purpose and then only by an absolute majority of the Board.

5.14. An act or decision of the Board is not invalid by reason only of a vacancy or vacancies in the office of a member or defect or irregularity in the appointment of a member.

5.15. The Board may meet in person, or by using technology that provides a means of audio or audiovisual communication (which permits all directors present at the meeting to hear each other), or by using a combination of meeting in person and using such technology.

5.16. A Board member present at the commencement of a meeting of the Board (whether in person or by using technology) will be presumed to have been present for the whole meeting, unless the minutes record that the person was not present at or after a particular time.

6. **OFFICIAL SEAL**

6.1. The Board must keep the official seal of the Health Service in safe custody.

6.2. The official seal of the Health Service must not be affixed to any document or item except by order or ratification of the Board. The seal must be affixed in the presence of a member of the Board and the Chief Executive Officer who will testify by their signatures that the seal has been duly affixed.

7. **DIRECTIONS**

7.1. The Board must comply with any directions given by the Secretary or the Minister for the Department under the Act.

8. **CONDITIONS OF FUNDING**

8.1. The Board must comply with any conditions of funding issued by the Department or the Commonwealth, or as required by the Funding Guidelines.

8.2. The powers and duties of the Health Service are subject to any health service agreements made between the Health Service and the Department in accordance with the Act.

9. **CHIEF EXECUTIVE OFFICER**

9.1. A Chief Executive Officer will be responsible for the day to day management of the Health Service.

9.2. The Chief Executive Officer’s appointment must be in accordance with the Act and GSERP, and must have Secretary approval.

10. **CHIEF FINANCE AND ACCOUNTING OFFICER**
10.1. The Board must appoint a person as Chief Finance and Accounting Officer in accordance with the Finance Directions.

10.2. The responsibilities of the Chief Finance and Accounting Officer include:

10.2.1. endorsing financial reports submitted to the Board and senior management of the Health Service; and

10.2.2. ensuring that the financial information in such reports is endorsed as to its completeness, reliability and accuracy.

11. **DELEGATION**

11.1. The Board may delegate any of its powers or functions (other than its power of delegation) to any employee of the Health Service or to a Committee.

12. **COMMITTEES**

12.1. The Board:

12.1.1. must establish the Committees listed in clause 12.2, and any other Committees required under Commonwealth or Victorian law, regulations or directives; and

12.1.2. may establish any other Committees as it considers necessary or convenient in order for the Health Service to carry out its functions or achieve its objects.

12.2. The Board must establish the following Committees:

12.2.1. Audit Committee (in accordance with the Finance Directions); and

12.2.2. Finance Committee (in accordance with the Act)

12.2.3. Quality and Safety Committee (in accordance with Act); and

12.2.4. Remuneration Committee (in accordance with the Remuneration Policy).

12.3. In establishing each Committee, the Board must specify:

12.3.1. the name and directorship of the Committee;

12.3.2. the terms of reference of the Committee;
12.3.3. the chair of the Committee;

12.3.4. the quorum of the Committee;

12.3.5. any delegation of authority to the Committee in accordance with clause 11.1;

12.3.6. the rules and procedures of the Committee;

12.3.7. the manner in which the Committee must report to the Board in respect of the Committee’s meetings and deliberations; and

12.3.8. any other matters required under Commonwealth or Victorian laws, regulations or directives.

12.4. Subject to any requirements under Commonwealth or Victorian laws, regulations or directives:

12.4.1. Committee directors will be appointed by the Board for a period of twelve (12) months and be eligible for reappointment; and

12.4.2. the Board may remove a member appointed to any Committee in its absolute discretion.

12.5. Should a vacancy occur on any Committee, it will be for the Board and not the Committee to fill the vacancy.

12.6. Committees may not co-opt directors without the approval of the Board.

12.7. Committees may establish sub-committees, however directors of a sub-committee may only be drawn from the Committee of which it is a sub-committee.

13. **ANNUAL MEETING**

13.1. The Annual Meeting of the Health Service will be advertised and held in compliance with the Act.

14. **ANNUAL REPORT**

14.1. The report of operations and financial statements will be prepared and submitted by the Board in accordance with the Act, the *Financial Management Act 1994* (Vic), and any other applicable legislation.

15. **CODES OF CONDUCT**

15.1. Board directors must comply with any applicable codes of conduct issued by the Public Sector Standards Commissioner under the *Public Administration Act 2004* (Vic).
16. **REMUNERATION AND CONDITIONS OF EXECUTIVE STAFF**

16.1. The Board must comply with any applicable directives or guidelines (including those issued by GSERP) issued by the Victorian Government or any department of the Victorian Government which relates to the remuneration or conditions of employment of executive staff of the Health Service.

17. **AUDITING**

17.1. The Health Service will comply with the provisions of the Act, the *Audit Act 1994* (Vic), and any other applicable legislation by providing for audit of the financial statements of the Health Service by the Auditor-General.

18. **FINANCIAL ACCOUNTABILITY**

18.1. The Board will ensure that:

18.1.1. regular financial reports are examined and prepared in accordance with the Department’s accounting requirements, sound accounting principles and the Australian Accounting Standards;

18.1.2. appropriate financial controls are in place to maintain integrity;

18.1.3. all accountable forms are securely held and an adequate register for all such forms is maintained; and

18.1.4. such accounting books and records as are required by the Department and other statutory bodies are in the manner prescribed.

19. **INVESTMENT**

19.1. The Health Service may invest money in any manner authorised by law and in accordance with the Act for the investment of trust funds.

20. **ACQUISITION AND DISPOSAL OF ASSETS**

20.1. The Board may acquire and dispose of any assets of the Health Service in order to achieve its objects and in accordance with the Act, the Funding Guidelines and any other guidelines issued by the Department, and any directions of the Secretary.

20.2. In the event of amalgamation or closure of the Health Service:

20.2.1. any assets of the Health Service funded by the Commonwealth will be dealt with in accordance with any funding conditions contained in any agreement between the Health Service and the Commonwealth and after obtaining any necessary approvals of the Commonwealth; and
20.2.2. all other assets will be dealt with in accordance with the Act, any guidelines issued by the Department, and any directions of the Secretary.

21. **AMENDMENT**

21.1. The Health Service may alter or amend these By-Laws at any time, subject to the necessary approval of the Secretary in accordance with the Act.

**CERTIFICATION**

We the undersigned hereby certify that these By-Laws which have been signed by us on each page, are the By-Laws made by the Board of the Health Service and approved by the Secretary.

Title of authorised signatory: ..............................

..................................................
(Sign)

..................................................
(Print name)

Date:............................................

Title of authorised signatory: ..............................

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(Sign)

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(Print name)

Date:.............................................
Health Organisation Board Director Position Description

The role of a board is essentially to:

- Be accountable for the provision of high quality, safe clinical care
- Set the strategic direction and goals for the health service
- Be accountable for ensuring the organisation operates effectively and delivers its strategy
- Monitor and manage risk to the organisation
- Appoint and manage the performance of the Chief Executive Officer, and
- Provide accessible and engaged leadership to create and promote a healthy and just culture for the board and within the organisation.

Effective boards are inquisitive and undertake regular stakeholder engagement within and beyond the organisation. They actively seek and use information and intelligence to understand how well their services are meeting people’s needs and to ensure they are utilising opportunities to improve quality, safety and efficiency.

About Public Health Services

Public health services deliver health, mental health and aged care services in metropolitan and rural and regional Victoria. They are integral parts of the Victorian health system which promotes and protects Victorians’ health.

Public health service boards are accountable for the safety and quality of care delivered in their services. They must create an organisational culture and governance environment that places patients at the centre of everything the organisation does and promote continuous improvement.

About Public Hospitals

Public hospitals deliver health, mental health and aged care services in rural and regional Victoria and are integral parts of the Victorian health system which promotes and protects Victorians’ health.

Public hospital boards have a responsibility to create a governance environment that drives performance in a way that places patients at the centre of everything the organisation does and to drive improvements to performance within a culture of safety and quality.

About Multi Purpose Services

Multi purpose services provide a range of health and community services that best meet local community need. This may include public hospital services, health care services, aged care services, and community care services.

As with public hospitals, multi purpose service boards have a responsibility to create a governance environment that drives performance in a way that places patients at the centre of everything the organisation does and to drive improvements to performance within a culture of safety and quality.

About Early Parenting Centres

Early Parenting Centres are state wide early intervention and prevention health services. Their purpose is to provide parenting support to families during pregnancy and with children from birth to school age. They are part of a broader range of early intervention services which include Child FIRST and Integrated Family Services and Cradle to Kinder and are accredited health services specialising in parenting, infant health and early childhood development.

Department of Health & Human Services
Expectations of board directors

- Attend and actively participate in a minimum of 75 per cent of board meetings as well as any committee meetings they are involved in that are held during the year.
- Participate on a sub-committee of the board, and serve on one or more ad-hoc committees as necessary. Directors should be prepared to participate in Board Strategy Days, AGMs and other nominated events which may be part of the board’s calendar.
- Develop a full understanding of the organisation’s finances, scope of service, strategic context and legal framework.
- Act in good faith in the best interests of the organisation at all times.
- Act with the degree of care and diligence that a reasonable person might be expected to show in the role, and do not improperly use the position, or the information gained in the course of the role, to gain an advantage for themselves or someone else to the detriment of the organisation.
- Adhere to the Victorian Public Sector Commission’s directors’ code of conduct including bringing any actual or potential conflict of interest or any perceived conflict of interest to the attention of the chairperson of the board.
- Undertake identified and agreed training and development in order to fully discharge their responsibilities.

General attributes required of board directors

As public officials, board directors are expected to demonstrate:

- Commitment to the delivery of safe, high quality, person-centred care – a genuine interest in the fundamental purpose of the organisation and its role in the health care service system.
- Ability to use and interpret complex information – understanding the need for information on which to base decisions and the ability to use it to get to the crux of the issue quickly.
- Integrity and accountability – dedication to fulfilling a director’s duties and responsibilities, putting the organisation’s interests before personal interests and acting ethically.
- Effective teamwork – the ability to work well in a group, listen well, be open to different views, be tactful but able to communicate a point of view frankly.
- Confidence to provide constructive challenge and oversight – the curiosity to ask questions and the courage to persist in asking, and to challenge management and fellow board members where necessary.

Minimum competencies required of all board directors

All board members are required to have:

- Sufficient financial literacy to understand and interpret financial reports, in particular the audited financial statement in the organisation’s Annual Report.
- Sufficient clinical governance awareness to ensure the delivery of safe, high quality services is always front of mind (and to undertake training on this regularly).
- Sufficient legal literacy to understand the board’s primary obligations under its constituting legislation and other major legal obligations (such as occupational health and safety).
- Sufficient governance skills to understand the role of the board via its relationship with the organisation’s executive and the accountability mechanisms for the agency, including the board’s ultimate accountability to the Minister for Health.

This does not mean that every board member must be a clinician or an accountant or a lawyer, however, all must have these minimum competencies to discharge their duties as directors and to ensure delivery of high quality, safe clinical services.

Department of Health & Human Services

State Government Victoria
Selection criteria

The following selection criteria are required to be addressed as part of the application submitted by interested candidates:

1) In addition to the required core competencies outlined above, possession of demonstrable expertise or qualifications in relation to one or more of the following disciplines would be advantageous (see below for definitions and requirements for each discipline):
   - Clinical governance
   - Patient (user) experience and consumer engagement
   - Strategic leadership / Executive Management
   - Corporate governance
   - Audit and risk management
   - Financial management and accounting
   - Asset management
   - ICT strategy and governance
   - Communications and stakeholder engagement
   - Human resources management
   - Community Services
   - Law
   - Registered Clinician

   It is not necessary to have experience in every discipline. Your application should address no more than three of these disciplines.

2) Continuing high levels of performance in your field of endeavour.

3) Appreciation or understanding of the broader policy context and issues surrounding the delivery and planning of public health and/or community services, including to those marginalised or disadvantaged in the community such as Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) families and people with a disability.

Please note every board needs to have at least one member in each of the following categories. If you fulfil one of these requirements, it would be helpful to highlight this in your application:
   - A person with demonstrable user experience and patient engagement skills.
   - A health professional with knowledge of contemporary clinical practice and experience in clinical governance and not employed in the hospital/health service concerned or where there is a conflict of interest that cannot be reasonably managed.
   - A person with professional qualifications in either Finance or Audit and Risk.
   - A qualified lawyer with expertise in corporate governance and/or the application and interpretation of law in the healthcare sector.

Appendix 6: Board papers example

6.1 Example Annual Agenda – Annual work plan or strategic workplace linked to Quality Initiatives

The health service board and annual agenda should be designed as a practical work plan where the board’s staple business items are allocated to a particular meeting. The example annual agenda below is one approach to the categorisation of items and their allocation to specific meetings. In this example, it is assumed there will be 12 meetings of the board including an annual strategy day. An underlying objective of the annual agenda is to achieve balance in the board’s workload through the year and ensure all board responsibilities are attended to. The items of business have been categorised as follows:

- matters that the board has resolved for its decision
- matters which have been delegated (e.g. to the CEO or a board committee)
- matters that are purely for information and do not require a board decision
- procedural matters that may arise at any or every board meeting.

The matters listed in the annual agenda and the scheduling of such matters will vary from health service to health service. Each board should identify the core matters for inclusion in the annual agenda. As well as the anticipated board business, there will be other matters which arise that require the board’s attention such as a compliance, clinical, policy or major capital expenditure issue. An annual agenda may be set out in many different ways.

The annual agenda should focus on the key areas of safety and quality which require improvement across the organisation. These improvements should be embedded into the organisation’s goals and objectives with clearly defined and measureable indicators of success. There should also be consideration of these safety and quality indicators for inclusion in the organisational safety and quality plan, the business plan and possibly the Statement of Priorities.
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<tr>
<td>Source</td>
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</tr>
<tr>
<td>CEO/CFO Report</td>
<td></td>
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</tr>
<tr>
<td>Committee reports</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Internal stakeholder feedback (staff surveys)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Internal KPI Reports</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
6.2 Example Board Agenda

The board agenda needs to be consistent and complete. It should include details of all matters for ‘noting’, ‘discussion’ or ‘decision’. Attendees and apologies should be documented and conflict of interest declarations must be a standing item, as should review and approval of prior meeting minutes, reports presented and other business.
# MEETING AGENDA

<table>
<thead>
<tr>
<th>Meeting no.</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and time</td>
<td>[Day] [Date] of [Month], [Year] at [Time]</td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
</tbody>
</table>

| Dial in Number | |
| Passcode | |

| Recipient List | |
| Attendees | |
| Guests | |
| Apologies | |

<table>
<thead>
<tr>
<th>Scheduled timing</th>
<th>Item no.</th>
<th>Item</th>
<th>Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insert]</td>
<td>1.</td>
<td>Opening formalities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1</td>
<td>Welcome and Apologies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>Confirmation of Quorum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>Confirmation of Agenda</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>2.</td>
<td>Declaration of Personal Interests</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1</td>
<td>Declaration of Personal of Interest</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>3.</td>
<td>In camera session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Board member discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>4.</td>
<td>Minutes of Previous Meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td>Review of Previous Minutes</td>
<td>3.1 Minutes of meeting no. X held DD/MM/YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See Attachment 3.1 Minutes of meeting no. X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>Actions Arising from Previous Minutes</td>
<td>3.1 Minutes of meeting no. X held DD/MM/YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See Attachment 3.1 Minutes of meeting no. X</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>5.</td>
<td>Reports</td>
<td></td>
</tr>
<tr>
<td>Scheduled timing</td>
<td>Item no.</td>
<td>Item</td>
<td>Attachments</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
<td>--------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>5.1</td>
<td>CEO Report/Discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.2</td>
<td>Board Chair Report/Discussion</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>6.</td>
<td>Safety and Quality and Consumer experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.1</td>
<td>Quality and Safety Performance Report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.2</td>
<td>Consumer experience reports and Patient Story</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>7.</td>
<td>Risk Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.1</td>
<td>Strategic Risk template</td>
<td>[Insert]</td>
</tr>
<tr>
<td></td>
<td>7.2</td>
<td>Review of Enterprise Risk Register</td>
<td></td>
</tr>
<tr>
<td>[Insert]</td>
<td>8.</td>
<td>Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.1</td>
<td>Presentation on one aspect of Strategic Plan</td>
<td>[Insert]</td>
</tr>
<tr>
<td>[Insert]</td>
<td>9.</td>
<td>Items for Decision</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Papers requiring board decision with clear details of the decision required]</td>
<td>[Insert]</td>
</tr>
<tr>
<td>[Insert]</td>
<td>10.</td>
<td>Items for Noting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.1</td>
<td>[Papers tabled highlighting relevance for noting]</td>
<td>[Insert]</td>
</tr>
<tr>
<td></td>
<td>10.2</td>
<td>Committee reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Board Committee Calendar and directorship – date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Finance committee - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Audit &amp; Risk committee - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality committee - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community Advisory committee - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Population Health - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Executive Performance and Remuneration - date of meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11.</td>
<td>Performance reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11.1</td>
<td>Internal reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinical services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical services</td>
<td></td>
</tr>
<tr>
<td>Scheduled timing</td>
<td>Item no.</td>
<td>Item</td>
<td>Attachments</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
|                  | 11.2    | External reports | - VHSPM  
|                  |         |            | - PRISM |
| [Insert]        | 12      | Other Business | [Items not on the agenda can be raised for discussion, subject to the chair’s permission] |
| [Insert]        | 13      | Critique of Board meeting | [To facilitate reflection and identify learning opportunities for the Board] |

**Next Meeting**

[Day] [Date] of [Month], [Year] at [Time]

[Location]
6.3 Example Board Minutes

Board minutes are important legal documents. They are relied on to demonstrate board consideration of relevant matters and the agreed outcomes. Board directors are required to review the minutes and formally approve them at the following meeting to confirm that they are a true and accurate reflection of the board processes and outcomes.
### MINUTES OF BOARD MEETING NO. [insert]

**Date and time**: [Day] [Date] of [Month], [Year] at [Time]

**Location**: [Location]

<table>
<thead>
<tr>
<th>In Attendance</th>
<th>[Name], [Title]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[List here board directors, and invited guests in attendance]</td>
</tr>
<tr>
<td></td>
<td>[If a board member is absent for any items(s) or period(s) of time during the meeting, record in brackets beside their name. If a board member attends remotely, note this beside their name.]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apologies</th>
<th>[Name], [Title]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chair (or presiding member)</th>
<th>[Name], [Title – if not chair]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Minutes</th>
<th>[Name], [Title]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time commenced</th>
<th>Item no.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insert]</td>
<td>1</td>
<td>Opening formalities</td>
</tr>
</tbody>
</table>

**1. Opening formalities**

1.1 Opening and Welcome.

‘The meeting was opened by the chair.’

1.2 Apologies.

‘As listed above.’

1.3 ‘Confirmation of Quorum.

There being X board directors present the required quorum of Y is satisfied.’

1.4 Confirmation of Agenda.

‘The board confirmed the agenda.’

[Note any additions made to the agenda]

<table>
<thead>
<tr>
<th>[Insert]</th>
<th>2. Conflicts of Interest</th>
</tr>
</thead>
</table>

**2. Conflicts of Interest**

2.1 ‘The board noted there were no conflicts of interest (real, potential or perceived) in relation to any item on the agenda.’

[If a conflict is declared, record:

- Who declared the conflict;
- A description of the interest and the conflict;
- The board’s decision as to whether the conflict is ‘material’; and
- The board’s decision as to what action will be taken to manage the conflict.]
<table>
<thead>
<tr>
<th>Time commenced</th>
<th>Item no.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insert]</td>
<td>3.</td>
<td>Minutes of Previous Meeting</td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Review of Previous Minutes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘The board <strong>endorsed</strong> the minutes of the previous meeting no. X as complete and accurate.’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[If amendments are made to the minutes, add: ‘subject to the following amendments’ and insert the amendments.]</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>Actions Arising from Previous Minutes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘The board <strong>noted</strong> the current status of the actions arising from the previous meeting no. X.’</td>
</tr>
<tr>
<td>[Insert]</td>
<td>4.</td>
<td>Safety and Quality Action Plans</td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td><strong>Title</strong> – [Insert title of Safety and Quality Action]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Insert short description of action being discussed.]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Discussion</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Insert summary of key considerations discussed leading to the board's decision, including any additional information presented at the meeting which was not attached to the agenda.]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outcome</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘The Board decided by a vote of X in favour, none against, on option B for [Safety and Quality Action Item – Title].’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Insert details of any agreed further actions to be taken, the responsible person and the due date.]</td>
</tr>
<tr>
<td>[Insert]</td>
<td>5.</td>
<td>Priority Items - For Decision/Discussion/Noting [Select and document the purpose of the agenda item]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>[Title</strong> – [Insert title of Item]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Insert short description of item being discussed.]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Discussion</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Insert summary of key considerations discussed leading to the board's decision, including any additional information presented at the meeting which was not attached to the agenda.]</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outcome</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘The board endorsed [Priority Item A – Title]’</td>
</tr>
<tr>
<td>Time commenced</td>
<td>Item no.</td>
<td>Item</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>[Insert]</td>
<td>6</td>
<td>Other Business</td>
</tr>
</tbody>
</table>

6.1  
**Title** – [Insert]  
**Description**  
[Insert short description of item being discussed.]  

**Discussion**  
[Insert according to whether the item was for noting, confirmation or decision.]  

**Outcome**  
[Insert according to whether the item was for noting, confirmation or decision. If a decision was made by the board, where applicable also insert details of dissenting, abstaining or absent directors.]  

6.2  
[As above if there are additional items of other business.]  

[Insert]  
7.  
**Critique of Board meeting**  

[Insert discussion of board directors regarding the current meeting, reflecting on:  
- What did we do well?  
- What did we not do so well?  
- What did we do that we could have done better?  
- Education opportunities?]  

8.  
**Meeting close**  

8.1  
**Next meeting date**  
‘The next board meeting will be held [Day] [Date] of [Month], [Year] at [Time] at [Location].’
<table>
<thead>
<tr>
<th>Time commenced</th>
<th>Item no.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.2</td>
<td>‘The meeting was closed at [Time].’</td>
</tr>
</tbody>
</table>

Signed as a true and correct record

<table>
<thead>
<tr>
<th>Chair</th>
<th>[Signature of chair]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>[Insert name of chair]</td>
</tr>
<tr>
<td>Date</td>
<td>[DD/MM/YYYY]</td>
</tr>
</tbody>
</table>
6.4 Example Risk Register

Risks must be regularly reviewed by the board in a concise but meaningful way. The following example risk register shows one way in which risks can be presented. A 'risk matrix' gives effective visual, high level information in 1-2 pages. This can be supported by a more detailed risk register of key risks, mitigation actions and an assessment of their effectiveness (two examples of which are provided below. The first provides more detailed analysis of risk (using Risk No.1 'Workforce strategy and management' as the example. The second one shows a more concise version. The preferred version will depend on the level of detail the board wants to see).
Appendices / 316

RISK MATRIX

Risk Rating
Heat mapping

Consequence
- Insignificant
- Minor
- Moderate
- Major
- Catastrophic

Likelihood
- Almost Certain
- Likely
- Possible
- Unlikely
- Rare

Extreme
High
Medium
Low

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Workforce strategy and engagement</td>
</tr>
<tr>
<td>2</td>
<td>Hospital acquired infection</td>
</tr>
<tr>
<td>3</td>
<td>Delayed access</td>
</tr>
<tr>
<td>4</td>
<td>Financial stability</td>
</tr>
<tr>
<td>5</td>
<td>Health Information management</td>
</tr>
<tr>
<td>6</td>
<td>Capital and Infrastructure – Site 1</td>
</tr>
<tr>
<td>7</td>
<td>Capital and Infrastructure – Site 2</td>
</tr>
<tr>
<td>8</td>
<td>Capital and Infrastructure – Site 3</td>
</tr>
<tr>
<td>9</td>
<td>Staff Safety</td>
</tr>
<tr>
<td>10</td>
<td>Serious patient harm due to falls</td>
</tr>
<tr>
<td>11</td>
<td>Abnormal results escalation</td>
</tr>
<tr>
<td>CONSEQUENCE</td>
<td>DESCRIPTORS</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Unexpected death or permanent disability of multiple patients, staff, contractors or visitors.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td>Major</td>
<td>Unexpected death or serious injury to a patient, staff member, visitor or contractor requiring significant medical or surgical intervention. Includes staff experiencing any 'time lost to injury' in more than 13 working weeks.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Service / Operational</td>
</tr>
<tr>
<td></td>
<td>Environmental</td>
</tr>
<tr>
<td>Moderate</td>
<td>Injury to a staff member, patient or visitor requiring medical or surgical intervention. Includes staff experiencing any ‘time lost to injury’ in 2 - 13 working weeks.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Service / Operational</td>
</tr>
<tr>
<td></td>
<td>Environmental</td>
</tr>
<tr>
<td>Minor</td>
<td>Minor injury requiring first aid treatment only. Includes staff experiencing any ‘time lost to injury’ in 1 – 10 working days.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Service / Operational</td>
</tr>
<tr>
<td></td>
<td>Environmental</td>
</tr>
<tr>
<td>Insignificant</td>
<td>No injury sustained.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Service / Operational</td>
</tr>
<tr>
<td></td>
<td>Environmental</td>
</tr>
</tbody>
</table>
## BOARD RISK REGISTER (Example 1)

### 1. Workforce Strategy and Management

<table>
<thead>
<tr>
<th>Description</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk that Hospital XX Clinical workforce pipeline is not equipped to meet future demands for services,</td>
<td></td>
</tr>
<tr>
<td>• The existing clinical workforce mix from both a cost and workforce supply perspective will not be optimal to meet the challenge the health service faces with growth in demand for services. Our ability to address is constrained by political and industrial climate</td>
<td></td>
</tr>
<tr>
<td>• Some highly specialised areas of hospital operations have insufficient succession strategies and struggle to attract and recruit clinical staff</td>
<td></td>
</tr>
<tr>
<td>• Iconic clinical services and individuals don’t have targeted succession and retention strategies in place</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status:</th>
<th>Residual Risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood- Almost certain</td>
</tr>
<tr>
<td></td>
<td>Consequence-Moderate</td>
</tr>
<tr>
<td>Rating:</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category:</th>
<th>Inherent Risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service/Operational</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controls/ Action taken</th>
<th>Timeframes for actions</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>•</td>
<td></td>
<td>Director HR</td>
</tr>
</tbody>
</table>
Risk registers can also be prepared in a table format. This format provides a ‘dashboard’ view of the risks, how it is trending and management and board accountability/oversight.

### BOARD RISK REGISTER (Example 2)

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Risk Description</th>
<th>Risk Category</th>
<th>Risk Direction (increasing, decreasing, constant)</th>
<th>Current Score (*)</th>
<th>Management Oversight</th>
<th>Board Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inability to attract and retain key personnel.</td>
<td>Operational</td>
<td>Increasing</td>
<td>![Score Icon]</td>
<td>HR Director</td>
<td>Committee A</td>
</tr>
<tr>
<td>2</td>
<td>[Insert risk description]</td>
<td>Clinical</td>
<td>[Insert risk direction]</td>
<td>![Score Icon]</td>
<td>[Insert]</td>
<td>Committee B</td>
</tr>
<tr>
<td>3</td>
<td>[Insert risk description]</td>
<td>[Insert risk category]</td>
<td>[Insert risk direction]</td>
<td>![Score Icon]</td>
<td>[Insert]</td>
<td>Committee B</td>
</tr>
<tr>
<td>4</td>
<td>[Insert risk description]</td>
<td>[Insert risk category]</td>
<td>[Insert risk direction]</td>
<td>![Score Icon]</td>
<td>[Insert]</td>
<td>Committee D</td>
</tr>
<tr>
<td>5</td>
<td>[Insert risk description]</td>
<td>[Insert risk category]</td>
<td>[Insert risk direction]</td>
<td>![Score Icon]</td>
<td>[Insert]</td>
<td>Committee C</td>
</tr>
</tbody>
</table>

**Overall rating:** Within tolerance

### Assessment of Actions to Manage Risk

<table>
<thead>
<tr>
<th>(*)</th>
<th>Assessment of Actions to Manage Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Score Icon]</td>
<td>Meets requirements—The risk management processes are appropriate for the level of risk identified.</td>
</tr>
<tr>
<td>![Score Icon]</td>
<td>Needs strengthening (minor)—Minor improvements in the risk management process are necessary to meet requirements.</td>
</tr>
<tr>
<td>![Score Icon]</td>
<td>Needs strengthening (important)—Risk management processes need to be strengthened in important ways to meet requirements.</td>
</tr>
<tr>
<td>![Score Icon]</td>
<td>Needs strengthening (critical)—Risk management processes are clearly deficient in critical ways.</td>
</tr>
<tr>
<td>![Score Icon]</td>
<td>Unestablished—Risk management processes have not yet been established.</td>
</tr>
</tbody>
</table>
6.5 Example Strategic Reporting Dashboard

Strategic reporting should be concise. It needs to convey a snapshot of progress against agreed targets using agreed measures. It should also include an overall status of overall progress and against key milestones. Risks and delays should be noted for board consideration and/or decision-making.
STRATEGY REPORTING TEMPLATE

1. Strategic Objective
[Insert a short description of the initiative being undertaken, including linkages to the organisational strategy]

2. Timeline

<table>
<thead>
<tr>
<th>Action / Milestone</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>J</td>
<td>J</td>
</tr>
<tr>
<td>1. [Insert Action/Milestone]</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2. [Insert Action/Milestone]</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>3. [Insert Action/Milestone]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. [Insert Action/Milestone]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. [Insert Action/Milestone]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key
- Green: Completed
- Yellow: In progress
- Blue: Planned to commence
- Red: Reporting date

3. Status Update

<table>
<thead>
<tr>
<th>Date</th>
<th>Narration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[Status of key actions and deliverables]</td>
</tr>
<tr>
<td></td>
<td>[highlight key risks and link to risk register]</td>
</tr>
</tbody>
</table>

4. Action Plan

<table>
<thead>
<tr>
<th>#</th>
<th>Action / Milestone</th>
<th>Anticipated completion date</th>
<th>Revised completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 5. Resources

<table>
<thead>
<tr>
<th>Resource requested ($, people, other)</th>
<th>Justification</th>
<th>Status (Y/N/Pending)</th>
<th>Approver and date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Insert justification]

## 6. Partnerships

<table>
<thead>
<tr>
<th>Details</th>
<th>Justification</th>
<th>Status (Y/N/Pending)</th>
<th>Approver and date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 7. Other issues for consideration

---

### Noted

<table>
<thead>
<tr>
<th>Management sign off</th>
<th>[Signature of responsible board member]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>[Insert name of responsible executive]</td>
</tr>
<tr>
<td>Noted by the board</td>
<td></td>
</tr>
</tbody>
</table>
6.6 Example Board Skills Matrix

A board skills matrix provides a snapshot of each director and the skills and attributes needed across the board. A board assessment is an important step in determining the necessary skills for the board (many of which are consistent across health services). DHHS’ board assessment resources are useful tools for self-assessment of director skills against the needs of the health service.

The value of the skills matrix is ultimately derived from honest self-assessment. Individual directors are not expected to meet all the criteria. The objective is to ensure that collectively the board has the relevant skills and diversity. The value of the matrix is that it clearly identifies any training or recruitment needs.
| Board member | Gender | Year elected | Years of tenure | Meeting attendance | Current position | Risk management | Government understanding | HR / People management | Disability Support | Community Engagement | Governance experience | Legal Understanding | Free of conflicts | Gender balance | Financial literacy | Length of Service | Boardroom experience | Financial literacy | AICD qualification | Connectedness to influence key stakeholders | Nominated regulatory experience and understanding | Experienced risk practitioner | Clinical experience | Strategic management experience | Change leader | Collaborative | Values alignment | Ability to achieve consensus |
|--------------|--------|--------------|----------------|-------------------|------------------|----------------|----------------------|------------------------|--------------------|-------------------|----------------------|-------------------|----------------|-------------|----------------|----------------|-------------------|----------------|-------------------|-----------------------------|-----------------------------|-----------------------------|-----------------|----------------|----------------|----------------|
| Female       | 2011   | 6            | /5             | 5                 | Director         |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |
| Male         | 2011   | 6            | /5             | 5                 | Deputy Chair     |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |
| Female       | 2017   | 1            | /5             | 1                 | Chair            |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |
| Male         | 2002   | 15           | /5             | 5                 | Director        |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |
| Male         | 2012   | 5            | /5             | 5                 | Director        |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |
| Male         | 2013   | 4            | /5             | 5                 | Director        |                |                      |                        |                    |                   |                     |                   |                |              |                |                |                   |                |                   |                            |                            |                            |                |                |                |                |

**Behaviours**
- **General**: Mandatory
- **Expertise**: High, Medium, Limited

**Male / Female**: 10%

- **High**: Is highly qualified in this area
- **Medium**: Is skilled / experienced in this area
- **Limited**: Has some exposure in this area
<table>
<thead>
<tr>
<th>Board member</th>
<th>Gender</th>
<th>Year elected</th>
<th>Years of tenure</th>
<th>Meeting attendance</th>
<th>Current position</th>
<th>Areas of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>2011</td>
<td>6</td>
<td>/5</td>
<td>Director</td>
<td>Asset management</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Male</td>
<td>2011</td>
<td>6</td>
<td>/5</td>
<td>Deputy Chair</td>
<td>Audit and risk management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2017</td>
<td>1</td>
<td>/5</td>
<td>Chair</td>
<td>Clinical governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2002</td>
<td>15</td>
<td>/5</td>
<td>Director</td>
<td>Communications and stakeholder engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2012</td>
<td>5</td>
<td>/5</td>
<td>Director</td>
<td>Community Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2013</td>
<td>4</td>
<td>/5</td>
<td>Director</td>
<td>Corporate governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Male / Female** 10%

- **High**: Is highly qualified in this area
- **Medium**: Is skilled / experienced in this area
- **Limited**: Has some exposure in this area
6.7 Example Professional Development Calendar
The professional development calendar provides an overview of relevant education sessions that should be made available to directors. The calendar is developed and updated by each individual health service in accordance with identified needs and skills gaps that exist within the board.

<table>
<thead>
<tr>
<th>Event Description</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aug</td>
<td>Sep</td>
</tr>
<tr>
<td><strong>Department of Health and Human Services (DHHS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board induction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Victorian Healthcare Association (VHA)</strong></td>
<td>16 Aug</td>
<td>6 Sep</td>
</tr>
<tr>
<td>Our health workforce: Tackling the challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure &amp; capital challenges for health services</td>
<td>6 Sep</td>
<td></td>
</tr>
<tr>
<td>Annual Conference</td>
<td>6-7 Oct</td>
<td></td>
</tr>
<tr>
<td><strong>Australian Centre for Healthcare Governance (ACHG)</strong></td>
<td></td>
<td>9 Sep</td>
</tr>
<tr>
<td>Roundtable: The consumer's role in strategy</td>
<td>9 Sep</td>
<td></td>
</tr>
<tr>
<td>The CEO and Chair/Board relationships - A webinar hosted by Conscious Governance</td>
<td>1 Oct</td>
<td></td>
</tr>
<tr>
<td>Clinical Governance: The board’s key responsibilities</td>
<td>21 Oct</td>
<td></td>
</tr>
<tr>
<td><strong>Australian Healthcare and Hospital Association (AHHA)</strong></td>
<td></td>
<td>8 Aug</td>
</tr>
<tr>
<td>The Healthcare Facilities Design and Development Summit</td>
<td>8 Aug</td>
<td></td>
</tr>
<tr>
<td>International Forum on Quality and Safety in Healthcare</td>
<td>26 Sep</td>
<td></td>
</tr>
<tr>
<td><strong>Victorian Managed Insurance Authority (VMIA)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk for Boards (Health)</td>
<td>16 Nov</td>
<td></td>
</tr>
<tr>
<td><strong>Women on Boards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Event Description</td>
<td>Month</td>
<td>Year</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>Financial Literacy for the Boardroom</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Realising your board potential</td>
<td>Aug</td>
<td>2017</td>
</tr>
</tbody>
</table>

**Australian Institute of Company Directors (AICD)**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders' Edge Luncheon</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Governance for directors</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Finance for directors</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Strategy and Risk for Directors</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Boardroom Financial Acumen</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Webinar : Is technology changing health care and institutions</td>
<td>Aug</td>
<td>2017</td>
</tr>
<tr>
<td>Chair Series Event</td>
<td>Sep</td>
<td>2017</td>
</tr>
<tr>
<td>Leadership in the Boardroom</td>
<td>Sep</td>
<td>2017</td>
</tr>
<tr>
<td>Evaluating the Board</td>
<td>Sep</td>
<td>2017</td>
</tr>
<tr>
<td>Healthcare Breakfast</td>
<td>Sep</td>
<td>2017</td>
</tr>
<tr>
<td>Mastering Financial Governance</td>
<td>Oct</td>
<td>2017</td>
</tr>
<tr>
<td>Applied Risk Governance</td>
<td>Oct</td>
<td>2017</td>
</tr>
<tr>
<td>Essential Directors Update</td>
<td>Oct</td>
<td>2017</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
</table>
Appendix 7: Financial reports example

Financial reports should be designed to provide the board with details of how the health service is progressing in terms of its financial performance to date, and provide a projection of the health service’s position in the future.

The Financial Report should be tabled as a standing agenda item at every board meeting. Some of the key areas that a financial report should include are:

- Financial Report Summary
- Operating Statement
- Balance Sheet
- Acute/Sub Acute Activity
- Employee Expenditure/FTE Reporting
- Operating Result by Program
- Treasury Report
- Cash Flow Report
- Other Indicators Report
- Saving Initiatives
7.1 Financial Report Summary

The summary of the report below details how the health services can provide an update of their overarching financial performance and provide an update of their projected result.

FINANCIAL REPORT [Month 20XX]

Financial Report

Strategic & Specific Matters

Cash Position

A letter has been sent to the Minister raising concerns that the cash issues experienced by [INSERT Organization Name], despite the strategies deployed prior to the end of the [20XX/20XX] financial year, have not been resolved in a sustainable manner and seeking a meeting as soon as possible to discuss the situation.

The CEO and Board Members met with Individual X to discuss current cash challenges.

Projected Result [20XX/20XX]

The projected result for [20XX/20XX] has worsened as details of the recently approved Health & Allied Services, Managers and Administrative Workers Enterprise Agreement [20XX-20XX] have been assessed.

The increase awarded was [XXX]% effective [Day Month 20XX]. A sign on bonus of [XXX] per FTE will cost in excess of [XXX].

Correspondence was received on [Day Month] advising that funding supplementation will be provided equivalent to the difference between the [XX.XX]% Government standard rate of annual pay increase which has already been funded and the [XX.XX]% increase that has been awarded. The notice received is silent on the specific funding for the sign on bonus.

The quantum of funding is unknown at this time and is therefore excluded from the projected result. It is expected to be advised and received in early [20XX].

[Month] Commentary

Performance Year to date

The actual result is a deficit of [XXX] which is [XXX] behind/ahead of budget expectations year to date. The result before Capital items is a surplus of [XXX] which is [XXX] behind/ahead of budget expectations, whilst the result for Depreciation and Capital items is [XXX] better/worse than budgeted due to [XXX].

Acute activity was over target year to date by [XX.XX] WIEE. Activity continued to be high in [Month] and is expected to remain so during [Month] in the lead up to the [Month] / [Month] closure.

To date the proposed changes to the [XXX] to allow the calculation of the new Sub Acute WIEE achieved against target have not been implemented. A proxy for reporting activity has been used which is based on the weighted bed day approach that was used previously. On this basis, the funded activity is slightly behind of target while actual occupancy remains high in the Sub acute ward.

[Insert Departmental] occupancy has improved during [Month] in the aftermath of the recent spate of outbreaks. [Insert Departmental] occupancy is now at [XX.XX]% year to date and the occupancy in the [Insert Departmental] remains high at [XXX]%.

Financial Performance

The operating result prior to Depreciation & Capital items for the month of [Month] was a Deficit/Surplus of [XXX] compared to a budget surplus of [XXX] i.e., [XXX] behind/budget expectations. The result year to date is a Deficit/Surplus of [XXX] against a budgeted surplus of [XXX] i.e., [XXX] behind/ahead of expectations.
7.2 Operating statement

The Operating Statement details how the organisation is tracking to date on revenue and expenditure against budget. This goes beyond a Profit and Loss which only details actual revenue and expenditure.

### Operating Statement

**[Month 20XX]**

<table>
<thead>
<tr>
<th></th>
<th>Month Actuals</th>
<th>Month Budget</th>
<th>Month Variance to Budget</th>
<th>YTD Actual</th>
<th>YTD Month Budget</th>
<th>YTD Variance to Budget</th>
<th>Month-Month Variance</th>
<th>Month-Approved Variance</th>
<th>Board Approved Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Inpatient Fees</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Resident Fees</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
<td>Commonwealth Grants</td>
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<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Outpatient Fees</td>
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<td>XXX</td>
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<td>XXX</td>
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<td>XXX</td>
<td>XXX</td>
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<tr>
<td>DH Indirect Contributions</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>Government Grants - Other State</td>
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<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Other Revenue</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>Interest Revenue</td>
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<tr>
<td><strong>Total Revenue</strong></td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

| **Expense**           | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Salary & Wages       | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| S & W - Employee Entitlements | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Nurse Agency Expense | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Other Agency Expense/Internal | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Superannuation       | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Work Cover           | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Fee for Service - VMO Costs | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Food Supplies        | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Medical & Surgical Supplies | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Other Supplies and Consumables | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Drug Supplies        | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Domestic Supplies & Services | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Fuel Light Power & Water | XXX         | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Repairs & Maintenance | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Minor Equipment Purchases | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| Administrative Expenses | XXX       | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| Patient Transport    | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |
| **Total Expense**    | XXX           | XXX          | XXX                       | XXX        | XXX              | XXX                    | XXX                   | XXX                     | XXX                        |

Using red and green to show negative and positive variances (respectively) provides an easy reference to identify issues or trends. The key is to understand not only variances to budget month to month, but year on year as well.
### 7.3 Balance Sheet

Balance sheets depict the assets and liabilities and movements in the values of these over time. Balance can be impacted by cash movements, changes to valuations of assets/liabilities, staff movements, accounting treatments (such as depreciation). The most important ratio to consider in the balance sheet is the Total Liabilities do **NOT** exceed Total Assets.

Health services will have many items in the balance sheet. The board level report should focus on the key items only.

#### Balance Sheet

As at [Day Month 20XX]

<table>
<thead>
<tr>
<th>Current Assets</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on Hand &amp; at Bank</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Monies in Trust</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Patient Related Debtors</td>
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<td>XXX</td>
</tr>
<tr>
<td>Sundry Debtors</td>
<td>XXX</td>
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<tr>
<td>Stores</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Prepayments</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>GST Receivable</td>
<td>XXX</td>
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<td>XXX</td>
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<td>XXX</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Current Assets</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments in Joint Venture</td>
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<td>Debtor - DHHS LSL A/c</td>
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<tr>
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<td>XXX</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
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<td>(XXX)</td>
<td>(XXX)</td>
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<table>
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<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Current Liabilities</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creditors &amp; Accruals</td>
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<td>XXX</td>
</tr>
<tr>
<td>Accrued Expenses</td>
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<td>Monies in Trust</td>
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<tr>
<td>Other Accrued Expenses</td>
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<tr>
<td>Income in Advance</td>
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<tr>
<td>Other Current Liabilities</td>
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<td>XXX</td>
<td>XXX</td>
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<tr>
<td>DHHS Cash Loans</td>
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<tr>
<td>Provision for Employee Entitlements</td>
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<thead>
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<th>Non-Current Liabilities</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision for Employee Entitlements</td>
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<td>XXX</td>
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<tr>
<td>DHHS Cash Loans</td>
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<td><strong>Total Non-Current Liabilities</strong></td>
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<table>
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<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
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</table>

<table>
<thead>
<tr>
<th>Equity</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accum Surp/(Deficit)</td>
<td>(XXX)</td>
<td>(XXX)</td>
<td>(XXX)</td>
</tr>
<tr>
<td>Contributed Capital</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Reserves</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Surplus/(Deficit) Current Year</td>
<td>(XXX)</td>
<td>(XXX)</td>
<td>(XXX)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL EQUITY</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TOTAL LIABILITIES &amp; EQUITY</th>
<th>Month-XX</th>
<th>Month-XX</th>
<th>Current Year Opening Balance</th>
</tr>
</thead>
</table>

Balance sheets depict the assets and liabilities and movements in the values of these over time. Balance can be impacted by cash movements, changes to valuations of assets/liabilities, staff movements, accounting treatments (such as depreciation). The most important ratio to consider in the balance sheet is the Total Liabilities do **NOT** exceed Total Assets.

Health services will have many items in the balance sheet. The board level report should focus on the key items only.
7.4 Acute/Sub Acute Activity

As part of the financial report, there should always be a summary of how the health service is meeting WIES growth targets. WIES levels should consistently tracked throughout the year and variance levels should be reviewed.

Acute/sub-acute activity – [Month – YEAR]

1. Acute Activity
As discussed on many occasions, meeting the growth WIES targets allocated to [INSERT Health Service] in [20XX/XX] is a significant challenge and will provide some short term challenges. The immediate challenge has been to ensure activity levels were increased as quickly as possible as there has been a significant lead time experienced in the past to increase acute services.

The following summarises the key factors for the first quarter:
1. Acute WIES has increased by [XX or X.XX] % on last year’s activity
2. Inpatients have increased by [XX or X.XX] %
3. Bed days have remained stable with a reduction of [XX or X.XX] %
4. WIES(revenue) per bed day has increased by [XX or X.XX] %

It is worth noting that, whilst activity is close to the target [XX] % to the end of [Month], activity has been weighted more heavily in the second half of the year to reflect the commencement of new lists at [Location X].

The following table details YTD inpatient activity:

<table>
<thead>
<tr>
<th>Month</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
<th>XXX</th>
</tr>
</thead>
<tbody>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

Victorian Government funding for health services is based on individual patient needs, and funded in accordance with the Weighted Inlier Equivalent Separator (WIES) rating. All financial reports should include reference to the finding mix. Directors should be familiar with the funding/case mix profile for their health service and look for trends in the data, and commentary by management with respect to variations.
7.5 Employee Expenditure and FTE Reporting

A breakdown of employee expenditure, including sick leave and overtime should be included. Sick leave is an often unaccounted cost and can have significant impacts on health service budgets if not monitored.

Discussion on the key/most significant expense items is important to highlight changes and trends.

Labour is the largest costs for most health services and therefore some analysis and discussion on this expenditure item (and aspects of employee costs) is important for the board to receive regularly.

3. Employee Expenses

Basic Pay: [$XX.XX] mill [$XXX or X.XX] % over/under budget

Whilst under budget in the first quarter, there is some pressure on the basic pay budget and the following areas have been identified:

- There have been additional training shifts worked to manage some of the change associated with the increased workload.
- The new Theatre schedule will require additional FTE. The challenge is to find that FTE from within the savings identified in the Workforce review completed in [Month 20XX].
- Whilst the redesign of the medical rosters will result in a reduction in overtime, there will be an increase in HMO/Registrar positions.
- Accruals are being made for EBA outcomes that have not yet been finalised. There is some risk that the outcomes will place additional pressure on the salary budget. All EBAs will be finalised in the second quarter of the financial year.

Sick Pay: [$XX.XX] mill [$XXX or X.XX] % over/under budget

The continued increase in sick leave is a significant concern as this is an area that has increased over recent years and a projected improvement to [20XX/XX] levels has been built into the budget.

The following table details the sick leave hours by pay period as a % to total hours:

<table>
<thead>
<tr>
<th>PY YTD % Sick Hours to Total Hours</th>
<th>YTD % Sick Hours to Total Hours</th>
<th>Target % Sick Hours</th>
<th>Variance to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>X.XX%</td>
<td>X.XX%</td>
<td>X.XX%</td>
<td>X.XX%</td>
</tr>
</tbody>
</table>

![Sick Leave Hours By Pay Period](image)
The following benchmarking has been undertaken from the most recent Victorian Public Sector Commission Workforce Data reports [20XX/XX] ([20XX/XX] reports due in [Month 20XX]).

<table>
<thead>
<tr>
<th></th>
<th>Your organisation</th>
<th>Comparator group</th>
<th>Number</th>
<th>%</th>
<th>Average distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick and carers leave taken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2015</td>
<td>12.2 days</td>
<td>12.4 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>11.2 days</td>
<td>12.7 days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lost effort
Time lost to sick and carers leave taken represented in FTE staff and expressed as a proportion of total FTE (%). See Appendix A (page 37) for an explanation of the calculations.

<table>
<thead>
<tr>
<th>Lost effort in FTE staff</th>
<th>41.00</th>
<th>4.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of lost FTE effort</td>
<td>$2,038,504</td>
<td></td>
</tr>
<tr>
<td>The benefit of a 1% reduction in leave taken</td>
<td>$25,395</td>
<td></td>
</tr>
</tbody>
</table>

The above benchmarking indicates that for the year ending [Day Month 20XX], the health service was slightly better than the industry with 4.7% lost time compared to 5.1% industry average.

It is clear, however, that the trend is bad and the Executive and Management are committed to improvement.
Appendices

Graphs and tables are very useful tools for analysing trends and comparisons to prior year for forecast data.

Overtime \$[XX.XX]\ mill \$[XXX] or [XX.XX] \% over/under budget
There has been an increase in overtime across the organisation, largely in the clinical areas as a result of the additional inpatient activity.

![Overtime Graph]

<table>
<thead>
<tr>
<th>DIVISION</th>
<th>YTD Actual $</th>
<th>PY YTD Actual $</th>
<th>Variance $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance &amp; Performance</td>
<td>$XXX</td>
<td>$XXX</td>
<td>$XX</td>
</tr>
<tr>
<td>Medical</td>
<td>$XXX</td>
<td>$XXX</td>
<td>-$XXX</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$XXX</td>
<td>$XXX</td>
<td>-$XXX</td>
</tr>
<tr>
<td>Nursing</td>
<td>$XXX</td>
<td>$XXX</td>
<td>-$XXX</td>
</tr>
<tr>
<td>Primary Care</td>
<td>$XXX</td>
<td>$XXX</td>
<td>-$XXX</td>
</tr>
<tr>
<td>Service Development</td>
<td>$XXX</td>
<td>$XXX</td>
<td>-$XXX</td>
</tr>
</tbody>
</table>

As per the above table, in excess/decrease of [XX] \% of the overtime expense relates to [Department] staff.

The increasing/decreasing cost of overtime was discussed at the most recent Medical Directors meeting and it was agreed reports detailing overtime expense would be provided to each Clinical Director.

There has also been an increase in overtime for nursing staff in [Insert Department]. This is reported to the monthly [Insert Team] meeting and there was discussion on the staff recruitment challenges and the pressure on the schedule due to the additional Theatre activity.

Other Agency Expenditure \$[XX.XX] mill \$[XXX] or [XX.XX] \% over/under budget
A number of Locum appointments have been made to address short term demands, particularly in the [Insert Department]. This is an area that will continue to be under pressure and will require offsetting savings in salaries.

Employee Entitlements \$[XX.XX] mill \$[XXX] or [XX.XX] \% over/under budget
This relates to [LSL] employee entitlements.
### 7.6 Operating Result by Program

It is important to breakdown the revenue and expenditure by Program. This can allow for decisions to be made in relation to which programs can be affected by financial decisions.

#### YTD Operating Result by Program

**Month 20XX**

<table>
<thead>
<tr>
<th>Description</th>
<th>Acute</th>
<th>Sub-Acute</th>
<th>RAC</th>
<th>Community</th>
<th>Commonwealth</th>
<th>Business Units</th>
<th>Total</th>
<th>Allocations</th>
<th>Allocated Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
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<td><strong>Total Patient Expenses</strong></td>
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<td>Repairs / Replacements</td>
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<td><strong>Total Non-Patient Expenses</strong></td>
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<td>XXX</td>
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<td>XXX</td>
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<td>XXX</td>
</tr>
<tr>
<td>Corporate TR</td>
<td>XXX</td>
<td></td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>XXX</td>
</tr>
<tr>
<td>Finance/IT/Supply/HR</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<td>XXX</td>
</tr>
<tr>
<td>Hotel TR</td>
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<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Revenue TR</td>
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<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td><strong>Total Transfers/Allocations</strong></td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Program Result after IV</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Interest</td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allocated Program Result</strong></td>
<td>XXX</td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The main purpose of this report is to provide the board with a high level summary of major operating expenditure items. This type of analysis can provide an insight into where major costs are incurred.
7.7 Treasury (Cash and Investments) Report

Treasury reports are critical for managing both cash flows and balance sheet items. This example provides a good summary of the total cash investments and cash / operating account balances.

<table>
<thead>
<tr>
<th>Issuer</th>
<th>Instrument</th>
<th>Account Number</th>
<th>Commenced</th>
<th>Maturity</th>
<th>Interest Rate</th>
<th>Credit Ratings</th>
<th>% of Total Term Deposits</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank X</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank X</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank X</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank X</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank X</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
<td>Term deposit</td>
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<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
<td>Term deposit</td>
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<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
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<td>DD-MM-Y1</td>
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<td>A-</td>
<td>X.XX%</td>
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</tr>
<tr>
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<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Y</td>
<td>Term deposit</td>
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<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Z</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Z</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Z</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Z</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>A-</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank Z</td>
<td>Bank Total Term Deposits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank A</td>
<td>Term deposit</td>
<td>XXX</td>
<td>DD-MM-Y1</td>
<td>DD-MM-Y1</td>
<td>X.00%</td>
<td>AAA</td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
<tr>
<td>Bank A</td>
<td>Bank A Total Term Deposits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X.XX%</td>
<td>XXX</td>
</tr>
</tbody>
</table>

Reconciliation back to the balance sheet and bank statements provides an additional level of comfort that the amounts reported are accurate. These balances should be checked back to the Balance Sheet.
Reconciling back to the balance sheet and bank statements provides an additional level of comfort that the amounts reported are accurate. These balances should be checked back to the Balance Sheet.
7.8 Cash Flow Report

This graph looks at the projected versus actual cash flow with a projected drop in cash flow later in the year due to forecast major capital expenditure.

Cash flows should, on the whole, be positive. A negative cash flow indicates that the health service’s revenue is not enough to meet its expenses. Over time, this will lead to insolvency.
7.9 Other Indicators report

Other indicators can be useful to help track cash flow, assets and upcoming expenditure. There is no set definition of what other indicators a health service should/could use. It will depend on the focus of the board and what measures they feel are important to monitoring the clinical and financial performance.

### FINANCIAL REPORT

**Month 20XX**

**Other Indicators Report**

(a) Analysis of Debtors

<table>
<thead>
<tr>
<th>Category</th>
<th>Current</th>
<th>90 Days</th>
<th>60 Days</th>
<th>30 Days</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Outpatients</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Residential Aged Care - Residents</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Provision for Doubtful Debts</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Total Patient Related Debtor</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Joint Venture</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Supply</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Provision for Doubtful Debts</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Total Supply Debtor</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>Total Debtors</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>% of total excluding Joint Venture</td>
<td>XXX%</td>
<td>XXX%</td>
<td>XXX%</td>
<td>XXX%</td>
<td>XXX%</td>
</tr>
</tbody>
</table>

(b) Potential and Written Off Bad Debts:

NIL

$ -

(c) Creditor Payments Processed for the Month:

$ XXXX.XXX

(d) Capital Equipment Purchases for Month XX:

<table>
<thead>
<tr>
<th>Purchase</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase 1</td>
<td>$ XXX</td>
</tr>
<tr>
<td>Purchase 2</td>
<td>$ XXX</td>
</tr>
<tr>
<td>Purchase 3</td>
<td>$ XXX</td>
</tr>
<tr>
<td>Purchase 4</td>
<td>$ XXX</td>
</tr>
<tr>
<td>Purchase 5</td>
<td>$ XXX</td>
</tr>
</tbody>
</table>

$ XXXXX.XXX
7.10 Savings initiatives

4. Key savings initiatives
The recent workforce review identified the following key initiatives for [20XX/XX].

1. Initiative 1
Insert Department Unit commenced operation on [Day Month 20XX] and insert Department Unit relocated to the Location X and commenced services [Day Month, 20XX].

Discussion on Initiative 1 recommendations put on hold until schedule adopted. Discussions scheduled to commence in Month, with the aim to implement a new structure on [Day Month, 20XX].

Responsible Exec – [Insert Responsible Exec]

2. Initiative 2
The first stage is the restructure. The anticipated implementation date is [Month 20XX].

Responsible Exec – [Insert Responsible Exec]

3. Initiative 3
Accept recommendation but need to be conscious of timing and staff available. This initiative has major risk implications that need to be addressed.

Responsible Exec – [Insert Responsible Exec]

4. Initiative 4
Business Case has been developed and approval by Executive has been obtained to commence the process of implementing [Action X]. Implementation planned for [Day Month 20XX].

Responsible Exec – [Insert Responsible Exec]

5. Initiative 5
Committee established to provide governance and leadership.

Initiative Target has been set at [XX%], Actual figure is currently 98%.

Responsible Exec – [Insert Responsible Exec]

5. Summary
The financial and activity result to [Month 20XX] is within budgeted expectations and the review indicates the full year budget is achievable. The major risks of meeting activity targets and managing costs structures are well understood and management strategies have been implemented.

FUNDING ISSUES: Nil

RECOMMENDATION: [Month YTD] financial and activity review is noted.
Appendix 8: Clinical reports example

The following example reports are based on board reports for an existing health service. They focus on elements of safe, quality care that all directors should understand and be reviewing regularly, together with guidance regarding key issues to look for.

### 8.1 Patient experience

Patient perceptions of our progress towards world’s best cancer care

**Victorian Healthcare Experience Survey (VHES) – April to June 2016**

<table>
<thead>
<tr>
<th>Overall Experience</th>
<th>2016</th>
<th>2016</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall care received while in hospital</td>
<td>96</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>Overall care and treatment from doctors</td>
<td>99</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Overall care and treatment from nurses</td>
<td>100</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>Overall care and treatment from other healthcare professionals</td>
<td>96</td>
<td>96</td>
<td>100</td>
</tr>
<tr>
<td>Doctors and nurses worked well together</td>
<td>92</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>Overall discharge process</td>
<td>90</td>
<td>92</td>
<td>96</td>
</tr>
<tr>
<td>Listened to and understood by staff</td>
<td>92</td>
<td>89</td>
<td>92</td>
</tr>
<tr>
<td>Treated with respect and dignity</td>
<td>92</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>Was not treated unfairly for any reason</td>
<td>95</td>
<td>85</td>
<td>86</td>
</tr>
</tbody>
</table>

Key trends to look for include:

1. Ensure that you understand what these benchmarks represent. E.g. what does statistically above peer average actually mean?
2. Look for, and query, clear signs of underperformance. Reasons for this should already be known given that it is a Q2 2015 data point. Reflect on the changes that were put in place to achieve the positive trend to achieve Q2 2016 result.
3. Look for dips and peaks in the data to understand if any issues might be behind the changes. Data should be trending positively or at least remaining constant and in line with peers.
4. Graphs can be a powerful way to show data and trends. Ensure that the graphs are accurately reflecting the data in the tables. Any discrepancies can indicate errors in the underlying data collection or report preparation processes.
Key points:

5. Underperforming areas should be clearly highlighted – use of ‘traffic light’ colours are common and clear.

6. Ask questions of management to understand the reasons for the poor result. Question whether management’s answers make sense based on what you know about what is happening in this health service in this area. For example, here there appears to be a recurring issue with respect to how staff engage with patients regarding their care. What issues within the organisation’s culture or staff training could be causing this? Given this is an ongoing issue, are the management actions to address this effective and appropriate?

7. It is also useful to understand what is driving improvement in results as there may be opportunities to apply similar management actions to other areas.

8. The colour coding clearly highlights that there are issues in this area. Management should be providing comments to explain these results. Here we have been provided with quotes from the survey responses, but no comments from management regarding actions developed to address the issues.

9. Consider these results against other areas of poor performance to look for key trends. In this example, when considered together with potential staff engagement issues noted in point 6 above, it may indicate that staff are not performing in a manner that is appropriate (compared with other health services). Dig deeper, through questioning management, to better understand any root cause / systemic issues with staff engagement. Are staff aware of these results? Would staff be able to shed light on these issues? Do staff survey/engagement responses provide any clues or evidence of training needs, organisational culture or morale issues?
10. The results here are consistent with other results in this report regarding staff engagement with patients.

11. This should be examined in more detail through understanding and identifying staff engagement issues through questioning management and direct engagement with staff through surveys. Management should be providing the board with information to support why these issues are arising and what actions have been considered or implemented to address them. The board may need to prove further to determine whether the explanations from management are sound and/or whether other actions need to be developed to address the issue/s.

12. Issues notes are made immediately obvious when traffic light reporting is used. Consider what might be happening within this health service given the feedback contained in these reports. E.g. what are the red flags telling you about staff engagement as part of the overall patient experience? Do management’s responses make sense in the context of what you are seeing in the data?
8.2 Quality indicators

This example report highlights key quality indicators and some of the commentary that is provided to the board by management.

1. **In-hospital mortality** – measures the number of deaths that occur in the health service for that month against the national average. Indicates potential issues with clinical practice.
   1. As reflected in the comments section – the data indicates that in-hospital mortality rates are tracking below the national average (depicted by the HSMR data line).
   2. Look for trends over time – in this instance the report clearly shows that the health service consistently tracks below the national average. As a director, ask questions to satisfy yourself of the significance of the data. E.g. tracking is below the national average, but is the national average too high?

2. **Incidents** – measures the number of ISR and non-ISR incidents during the month.
   3. Including a target (or ‘control limit’ in this instance) in graph format help to easily track against objectives and acceptable levels of incidents.
   4. Obvious issues in a particular period should be investigated. Management should expect the board to questions these obvious outliers and come to board meetings prepared to provide an explanation of the issue and remedial actions put in place.
   5. Management should provide comments on key issues (one-off events) or concerns regarding any systemic issues noted.
3 – Average Length of Stay (Days) for all DRG’s

Data Source: IPM
Comment on current month: Tracking within control limits.
Comment on previous month: No outliers past three months.

4 – Unplanned readmissions within 28 days per 1000 separations

Data Source: IPM
Comment on current month: Tracking within control limits
Comment on previous month: No outliers past three months.

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Average length of stay for all Diagnosis Related Groups (DRGs) – measures the average length of stay (LOS) against averages and control limits.

1. Including the data source can provide useful information.
2. Control limits can be at both upper and lower ends. In this instance, the average LOS target area is between 7.8 and 10 days. T
3. Can expect minor fluctuations each month, however results that are consistently at higher or lower ends, or that show a major spike (up or down) should be queried.

Unplanned readmissions – measures unscheduled readmissions due to recurrence or complications post-discharge. Indicates potential issues with quality of care provided in first admission.

4. Whilst comments indicate that there have been no outliers in the past three months, the data shows a consistent decline. Directors should understand what this means and be questioning management if they have concerns - asking for more detailed data, information or investigation if they feel it is necessary.
Hospital acquired SAB infections – measures infections caught during hospital stays. Indicates potential safety or practice with respect to infection control.

1. General trend downward indicating positive performance, especially when compared to control limits and current tracking against average. Reasons for anomalies such as those shown in October 2015 should be provided by management at the time.

Post-operative cases with Septis – another measure of infection control more specifically associated with surgical and post-operative procedures. Better results are those in the lower ranges.

2. Comments regarding data capture and reporting issues should be monitored as ongoing ‘gaps’ can indicate potential system or process issues that management and the board may need to address.
Medication incidents per 1000 bed days – measures incidents where incorrect doses were administered to patients. Indicates potential safety or practice issues with respect to safe and quality clinical practices.

1. Management comments provide clear details of the incidents and actions taken to address. The board’s role is to monitor the effectiveness and performance of these actions over time, especially as there has been a trend upward in the number of incident in the past few months up to July.

Hospital acquired DVT/PE - measures instances of deep vein thrombosis acquired during hospital stays. High incident rates indicates potential issues with wound management within clinical practices.

2. Directors should pay attention to trends like this which show a gradual increase in incident rates over time (spiking in December 2015) with an exception in May 2016. Directors should have an understanding regarding any underlying issues that might be causing this.
Patient identification incidents – measures incidents where patient information has been incorrect resulting in practice or treatment errors.

1. In this instance there is an obvious jump in incidents well above the control limit. Management have – as the board should expect - provided an explanation for the anomaly as well as details of the management actions in place to address the underlying issue.

Clinical handover incidents – measures incidents relating to transfer of patients between clinical services. This can indicate potential administrative, clinical practice or operational issues.

2. Trend indicates that incidents are regularly tracking close to control limits with some improvement and movement back towards the average.

3. The data appears to be quite volatile moving above and below the average. As directors, you should be asking – is this normal for this data? If not, what’s happening?
Pressure injuries per 1000 Inpatient Bed Days – measures incidents of pressure sores incurred during inpatient stays. Indicates quality of clinical practices in terms of patient management

1. This data is reporting highly variable performance. A key question for the board is ‘is this normal an in line with other health services?’ if not, what are the underlying issues.
2. Data is close to control limits on several occasions – this could be worth investigating in more detail

Medical emergency calls per 1000 separations

3. The data appears to be tracking in line with control limits and averages since Jan 2015.
8.3 Performance indicators

This example report highlights key performance indicators with respect to compliance and risk. It contains incident data and clinical indicators and is provided to the board on a quarterly basis.

Performance Indicator Report Trended Data -
As at Q2 - October to December 2015

This report summarises quality, compliance and risk indicators for 2015 – 2016.

The following incident data, clinical indicators and audit results are trended over the respective data reporting periods. Where possible we are moving to peer benchmarking for comparison data with support of the Benchmarking Project and with participation in the ACHS Clinical Indicator Program.

<table>
<thead>
<tr>
<th>Standard 1 – Governance for Health Services: Best Care – Personal, Connected &amp; Right, Safe</th>
</tr>
</thead>
</table>

**Clinical Incidents – Overview**

**Clinical Incidents – Q 2 October to December 2015**
- 22 clinical incidents
- 16 (72%) of clinical incidents occur on Acute
- Clinical incidents reported are below total for the same period last year (42) & incidents/quarter

**Summary:** Clinical incident reporting has reduced.

**Quality Improvement Activities** in relation to incident & near-miss reporting & investigation and consumer participation/experience continue with progress on Understanding Your Healthcare (Health Literacy) initiatives and SMART Patient Discharge advice.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>16</td>
<td>40</td>
<td>35</td>
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<td>0</td>
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<td>1</td>
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<tr>
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<td>4</td>
<td>0</td>
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<td></td>
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<tr>
<td>Perioperative</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MR Community</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Pharmacy</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidents – Total</td>
<td>28</td>
<td>22</td>
<td>48</td>
<td>42</td>
<td></td>
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</tr>
</tbody>
</table>

**Clinical Indicators** (Q2 SRHSM VAED Sept. 2015/16)

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</thead>
<tbody>
<tr>
<td>HSMR 381.5 (9 deaths)</td>
<td>No data Avail.</td>
<td>No data Avail.</td>
<td>No data Avail.</td>
<td>No data Avail.</td>
<td></td>
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</tbody>
</table>

**Comments** should always accompany results especially when there are gaps such as ‘no data Avail’.
Keeping data and information simple and easy to understand provides an efficient way of monitoring performance. Note: Ensure that you understand what the information represents. E.g. does the tick indicate that Health Service Accreditation is scheduled or completed for the period?

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</thead>
<tbody>
<tr>
<td>Overall Death in Low Mortality</td>
<td>0</td>
<td>No data Avail.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data only provided on Stroke &amp; Pneumonia in Q.1</td>
</tr>
<tr>
<td>DRG’s AMI</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured NOF</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.6</td>
<td></td>
<td></td>
</tr>
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</table>

**By exception report**

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</thead>
<tbody>
<tr>
<td>&lt;28 days</td>
<td>No data Avail.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*No results reported in SRUSM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety &amp; Quality</th>
<th>July-Sept 2016</th>
<th>Oct-Dec 2016</th>
<th>Benchmark</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service Accreditation</td>
<td>✓</td>
<td>✓</td>
<td>OWS December 2013/Mid Cycle Review May 2015. OWS due in August 2016 (under ACHS)</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Culture</td>
<td></td>
<td></td>
<td>89% April to June 2015</td>
<td></td>
</tr>
</tbody>
</table>
High Risk Audits

1. Data submitted for the [Service] Benchmarking (Oct.–Dec. 2015) shows 100% compliance with risk assessments for Pressure Injuries and Falls.

   Interventions/Actions:
   A review of Falls Management shows falls alerts need to be in place and medication reviews are required for patients at high risk of falls. The progress on the VTE Clinical Practice Guideline is due.

2. Urgent Care Clinical Practice Guidelines Audits have been completed for the management of Abdominal Pain and Stroke/TIA.

   Audit results indicate clinical practice according to guidelines & timely transfer to tertiary hospitals ranges from 85% to 90%.

   Interventions/Actions:
   The audit schedule results and improvements will be loaded into Risk Man Q.

Risk Register

Clinical Risk Register updated March 2016. The risk associated with breach of patient privacy/confidentiality was reviewed with control in place confirmed and the Risk Treatments revised as below. The risk remained rated as Low.

The high risk associated with the maternity service staffing has been towered with the recruitment to the vacant position.

Interventions/Actions

Controls–Confidentiality Policy. Medical records stored securely. Information security policies and procedures. Open Disclosure policy and procedures. Freedom of Information policies and procedures require signed authority to release records. New staff induction & orientation includes training on Confidentiality obligations. Employment Contracts, Volunteer Agreements, Students Agreements and Board member induction include requirement to sign Confidentiality Agreement.

Risk Treatments – Confidentiality Policy revised with Health Legal oversight and endorsed by BOM Feb. 2016. Revised the Company Secretary’s responsibilities for advising the dates, time and venues for meetings and distributing papers before meeting to include a specific check to confirm that no identifiable information is included with the papers relating to patients, staff, complainants, etc.

<table>
<thead>
<tr>
<th>Standard 2 – Partnering with Consumers: Care that is Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complaints</strong></td>
</tr>
<tr>
<td>Number of Complaints</td>
</tr>
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</table>

Clinical Indicators: Complaints resolved <28 Days = 100%

Additional information can provide more detail and show links to other areas of management, monitoring and oversight - including risk, compliance and operations.
Benchmarking data and statistical measures are useful, however directors need to ensure that they understand the relevance of these measures and what it means for the health service’s performance.

<table>
<thead>
<tr>
<th>Patient Experience – Satisfaction/Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>VHES Overall Results Overall Experience</strong></td>
</tr>
<tr>
<td>92.3% (n=50)</td>
</tr>
<tr>
<td>Participation Rate</td>
</tr>
<tr>
<td>42% (n=108)</td>
</tr>
<tr>
<td>Improvement in overall experience compared to previous quarter and the same period last year, remain above the state average. Increase in participants compared to previous quarter and the same period last year, with higher and lower participation rates as stated, remaining above state average. Action Plan being developed to address areas identified as contributing to overall decline in satisfaction in particular in relation to discharge requirements. SMART discharge is being developed.</td>
</tr>
</tbody>
</table>
There are a lot of ‘zero’ data being reported – you could question whether this is accurate or understand why the performance is so strong in these indicators.
Audit Results
Infection Control audits are on schedule according to Audit Schedule & reported to Clinical Practice Forum. Audits consistently demonstrating excellent results and opportunities to improve clinical practice guidelines.

Risk/Risk Register
5 risks specific to infection Prevention & Control are cited on Clinical Risk Register – relating to potential failure to report relevant incidents, potential failure to implement antimicrobial stewardship program, potential failure to comply with infection control practices, potential failure to prepare for pandemics and potential failure to provide adequate relevant consumer information.

All are rated as low risk with effective controls in place.

Interventions/Actions
Strategies to improve compliance with additional precautions, isolation guidelines and cleaning programs when indicated have been developed.
Procedure developed to manage Carbapenemase Producing Enterobacteriaceae (CPE) in line with new DHHS guidelines.
Standard 4 – Medication Safety: Best care that is connected & Right and Safe

Clinical Incidents

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<tr>
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</thead>
<tbody>
<tr>
<td>Prescription/Order/Decision</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispensing/Receipt</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration/Treatment</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>2</td>
<td>0</td>
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</table>

Comment: No medication incident have resulted in harm this period. Work continues on ensuring alerts and adverse drug reactions are managed according to policy.

Clinical Incidents

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<tr>
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<tbody>
<tr>
<td>Prescription/Order/Decision</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Dispensing/Receipt</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration/Treatment</td>
<td>5</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>2</td>
<td>0</td>
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</table>

Comment: Medication incident and near miss incidents now show more incidents reported relating to prescription. This is a change in the nature of incidents reported & demonstrates for the first time in two years’ that issues with prescribing (Doctor) are now being reported. There were no incidents relating to administration reported which have traditionally been the biggest group of incidents.

Audit Results

Medication Safety audits are managed according to Audit Schedule & reported to Clinical Practice Forum. Compliance with audits is currently overdue, with past results consistently showing excellent results. Data submitted the Benchmarking (Oct to Dec 2015) shows improvement with patients receiving written information regarding medication to discharge. Opportunities to continue to improve this performance are being followed up by the Medication Advisory Committee and Clinical Practice Forum.

Risk/Risk Register

2 risks specific to Medication Safety are cited on Clinical Risk Register – relating to potential failure to report relevant incidents and potential failure to comply with medication safety policies and practices. Both are rated as low risk with effective controls in place.

Interventions/Actions

Strategies to ensure staff work within their scope of practice (e.g. Endorsed Ens, RIPENs) as they related to medication checking and administration have been developed.

Plans to participate in the National Antimicrobial Prescribing Survey (NAPS) during Antibiotic Awareness Week will add to our antimicrobial stewardship program.

Plans to improve medication reconciliation and consumer information on discharge are underway.
Appendices

Standard 5: Patient ID & Procedure Matching: Best Care that is Connected & Right and Safe

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<tbody>
<tr>
<td>Patient Identification</td>
<td>2</td>
<td>2</td>
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</table>

Comment: Patient ID incidents continue to involve incorrect labelling of medical record forms.

Audit Results
Patient ID & Procedure Matching Audit is scheduled to be conducted twice each year. Data submitted (Oct to Dec 2015) shows compliance with patient ID bands is at 99%.

Risk/Risk Register
1 risk specific to Patient Identification and Procedure Matching is cited on Clinical Risk Register – relating to potential failure to comply with relevant policies and practices. This risk is rated as low risk with effective controls in place.

Interventions/Actions
Ongoing monitoring for patient identification incidents is in place along with an initiative to support real-time patient registration in IPM which will enable printing of ID labels for Urgent Care presentations (thus addressing the risk of incorrect patient ID at this point in care).

Standard 6: Clinical Handover: Best care that is Personal, Connected & Right and Safe

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<tbody>
<tr>
<td>Clinical Handover</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>

Comment: There have been no Clinical Handover incidents this quarter.

Audit Results
We are keen to ensure patients are actively involved in clinical handover and that they are encouraged and given time to ask questions about their care. Audit results in 2015 indicated we are on the right track, with this audit showing that 99% % of patients/carers were involved in handover at the bedside and patients were provided the opportunity to ask questions during handover.

Risk/Risk Register
1 risk specific to Clinical Handover is cited on Clinical Risk Register – related to potential failure to conduct adequate clinical handover. This risk is rated as medium risk with the need for better controls to be instigated.

Interventions/Actions
Data for patient Clinical Handover has now been submitted to the Benchmarking and we have implemented the new patients note pads. We are continuing to exploring strategies to enhance the discharge communication with GP practices & introducing a new Patient Discharge Form to support ongoing care after discharge.

Appendices / 359
Appendices

Standard 7 – Blood and Blood Products: Best Care that Is Safe

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<tr>
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<tbody>
<tr>
<td>Blood and blood products</td>
<td>0</td>
<td>0</td>
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</table>

Comment: There have been no clinical incidents in relation to blood and blood product with a low volume of transfusions.

Audit Results
2 transfusions administered between October – December 2015.
Data submitted (Oct to Dec 2015) shows compliance with consent for blood transfusion at 100%. There were no adverse reactions recorded and 100% of screening was completed.

Risk/Risk Register
1 risk specific to Blood Product administration is cited on Clinical Risk Register – relating to potential failure to comply with relevant policies and practices. This risk is rated as medium risk with the need for better controls to be instigated.

Interventions/Actions
Strategies to improve consent are in place involving education to the GP/VMO’s and Nursing staff and new Blood Product Management form has been developed for piloting over next 3 months.

Standard 8 – Preventing and Controlling Pressure Injuries: Best Care that Is Safe

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<tbody>
<tr>
<td>On Admission</td>
<td>7</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>On Acute</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>MRCN</td>
<td>0</td>
<td>0</td>
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Comment: There were no incidents relating to preventing and controlling pressure injuries for this period. We can see that pressure injuries are mainly present upon admission (as opposed to occurring during inpatient stay). The incidence is 0.00%. In additional to incident reports – we have completed a Coding File Audit for the same period and have confirmed only one case for the same period that was not reported on RHIMS.

Audit Results
Data submitted (Oct to Dec 2015) shows otherwise good compliance with patient pressure injury management at 100% for risk screening and management.

Risk/Risk Register
1 risk specific to pressure Ulcer Prevention is cited on Clinical Risk Register – relating to potential failure to identify at risk patients. This risk is rated as low risk with effective controls in place.

Interventions/Actions
An equipment audit is planned to review the resources available for managing pressure injuries.

Appendices / 360
Standard 9 – Clinical Deterioration: Best care that is personal, connected & right and safe

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<tbody>
<tr>
<td>Clinical Deterioration</td>
<td>4</td>
<td>4</td>
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</table>

Comment: The clinical incidents for clinical deterioration mainly relate to patients who are transferred out for higher level care as part of our clinical review procedures.

Audit Results

Monitoring of the deteriorating patient is based on an audit sample of patient charts confirming where a complete set of observations is part of the last set of recorded observations, in agreement with their monitoring plan.

In 2015, auditing indicated 90% compliance to documentation and 100% of escalation being completed.

Risk/Risk Register

TBA to be updated

Interventions/Actions

All transfers out from UCC, Theatre or Acute are reported under clinical deterioration.

In 2015-15 12 case reviews were completed for discussion in UCCAC, with other case reviews discussed in CPF and Obstetric Audit Committees to identify areas for improvement in case & clinical outcomes.

Standard 10 – Falls Prevention and Injury: Best Care that is Safe

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<tbody>
<tr>
<td>Falls Numbers</td>
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<tr>
<td>Falls</td>
<td>3</td>
<td>7</td>
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</tbody>
</table>

Falls 2015-2016

Appendices / 361
Comment: The clinical incidents for falls show one fall with minor injury and no falls with serious injury in Oct to Dec 2015.

Clinical Indicators
We have now submitted data to the ACHS clinical indicators and are waiting for results for July to December 2015 period.

Audit Results
Data submitted (Oct to Dec 2015) shows compliance with patient falls management at 100% with risk screening being completed.

Risk/Risk Register
TBA to be updated

Interventions/Actions
As above re ACHS clinical indicators program and falls alerts procedure and medication reviews for high risk patients are to be implemented.
Appendix 9: References and further reading


