LA TROBE
UNIVERSITY

LIVING WITH DISABILITY
RESEARCH CENTRE

2022 RESEARCH

SEMINAR SERIES

13 April

The research problem

- Commissions of inquiry and regulators recommend that boards govern for quality and safeguarding

  - Mid-Staffordshire NHS Trust review: "A theme of the evidence about the Board has been reliance on the distinction between strategic and operational issues and a disclaimer of responsibility for the latter."

  - Aged Care Royal Commission: "An aged care provider's most important objectives should be to enhance the wellbeing of older people by providing them with safe and high quality care and to put the older person's wishes and needs first ..."

- But how? What composition, structures and processes can be demonstrated to be effective?

Three overlapping arguments for board involvement

1. Boards have ultimate accountability for the organisation, incl. for Q&S

2. Boards can be a 'check and balance' on management

3. Board attention causes a cascade of attention down the hierarchy

PURPOSE AT WORK

Disability Royal Commission

> Public hearing 13

> "... disability support providers [should] implement governance structures and management processes that are representative and inclusive of the people who receive their services." (p. 98)

> "Had people with disability been directors of Sunnyfield ... there is every prospect that Sunnyfield's approach to its 'clients' would have been better informed and more supportive. (p. 100)

DRC on inclusion of people with intellectual disability on boards

> "we do not accept that people with disability, including people with cognitive disability, are incapable of filling the role of a director. …

> "The question of whether a particular person with disability can serve as a director has to be considered in the light of the supports that can and should be provided to that person." (p. 102)

> See also Bernadette Curryer's and my fact sheet, 'Inclusive governance'

DRC hearings

> Lines of questioning
>> Directors with expertise in abuse and neglect
>>> Very few such people
>> Directors who are advocates
>>> Conflicts of interest
>>> Assumes advocates willing
>>> Full range of expertise?

In my view, boards should include directors with disability, **and** directors with expertise in service delivery, quality and safeguarding*

A countervailing example about inclusion … RNIB, Britain

> A board entirely consisting of people with disability

> "… one of the worst examples we have uncovered of poor governance and oversight having a direct impact on vulnerable people. "

> "Protecting people from harm is not an overhead to be minimised, it is a fundamental and integral part of operating as a charity for the public benefit."

Legal expectations of directors of Australian disability support providers

- Corporations Act
  - Act creates the 'corporate veil': 'No soul to damn, no body to kick'. Hence, duties placed on directors.
  - General description of duties of directors
  - Duty of care and diligence – to the company, not to stakeholders
- Work health and safety
  - Due diligence obligations (s. 27) of executives and directors in all States other than Victoria
  - For executives, 'lifts the veil'
  - Conditionally lifts the veil for directors – if remunerated

Legal expectation cont.

- NDIS legislation
  - "Key personnel"
  - Code of Conduct for all providers and workers
    - Obligation to "promptly take steps to raise and act on concerns about matters that may impact … quality and safety"
    - Breaches can attract fines of up to $55,500 for individuals
    - Actually lifts the veil for executives
    - Potentially lifts the veil for directors
    - Depends on the interpretation of the Code of Conduct Rules: Are directors engaged "In providing supports or services to people with disability …"?
  - NDIS Practice Standards and Quality Indicators for registered providers
    - Governance and operational management
    - Emergency and disaster management

Normative expectations

> Boards have been told to govern more and manage less (Chait 1993; Ingram 1996, 2015)

> Sometimes led to beliefs that boards

>> need to be concerned with strategy, financial sustainability and supervision & support of the CEO

>> quality and safeguarding seen as operational issues

> Perceptions that directors only need to be concerned about financial solvency and worker health and safety

In health care in particular, these normative expectations have been modified

What's in a name?

> Quality and safeguarding

> In healthcare: "Clinical governance"

> In aged care: "Care governance"

> In non-clinical disability supports: "Service governance"; "Practice governance"?

Purpose at Work's Right on Board framework

RIGHT ON BOARD

7 Embed learning and action

1 Understand rights and responsibilities

2 Know about the people supported and the people supporting them

3 Know the risks

4 Assure that the basics are right

5 Assure that the risks are addressed

6 Understand when things are going right, and wrong

AICD Governing for Vulnerable People

1. Who are 'vulnerable' people
2. Impact of the Royal Commissions
3. The role of the board
4. Director's legal duties
5. The board's role in strategy and risk
6. Reputation and culture
7. Effective monitoring

Australian Institute *of*
Company **Directors**

Method – Literature search

> Very limited literature on disability provider boards
>> Exceptions: e.g., Beckwith et. al 2016; Rosenbaum & More 2021
> No academic literature on disability provider boards and quality & safeguarding
> Look to related literature
>> Boards of health organisations
>> Boards and WHS

Research question

> What can we learn from other sectors (hospitals and health sector; WHS) about boards of directors and quality, safeguarding and safety?

> How do boards help achieve improved quality, safeguarding and safety?

Theories of governance, incl. monitoring

> Principal-agent theory

> Stakeholder theory

>> ISO37000: Governance of Organizations

> However, neither theory gives guidance on how boards should discharge their responsibilities

Review articles

- Boards of hospitals and health care organisations
  - DeRegge & Eeckloo 2020
  - Erwin, Landry, Livingston et al. 2019
  - Millar, Mannion, Freeman et. al 2013
- Boards and WHS
  - Ebbevi, Von Thiele Schwarz, Hasson et al. 2021

What the hospital literature shows

> Small, but statistically significant, associations between board practice and outcomes (morbidity and mortality, and quality outcomes)

>> For patients: If you are entering hospital, hope that the hospital is well governed!

>> For directors: What you do matters, to the extent of life and death!

> Limitations: Point in time; correlation does not prove causation

What the hospital literature shows #2

- Jiang et al. (2009) demonstrated correlations with both process of care measures (for heart attack, heart failure and pneumonia) and risk adjusted mortality and:
  - provision of clinical quality data to the board, including national benchmarks
  - provision of patient safety data to the board, including national benchmarks
  - provision of patient satisfaction data to the board, including national benchmarks
  - most board meetings having a specific agenda item on quality
  - CEO and executive performance evaluation include measures for clinical improvement and patient safety
  - establishing strategic goals about quality, and
  - board involvement in setting the organisation's quality agenda.

What the WHS literature shows

> Strategies which are pursued to promote WHS are:
>> board-level attention, which then instigates attention at lower organisational levels (Lornudd et al., 2021)
>> board-level committees, with cascading committees at lower levels
>> a dedicated director portfolio for WHS
>> director training in WHS, including assessment of director competency
>> director site inspections
>> the promotion of a safety culture
>> enunciating a vision for WHS and determining policies
>> monitoring a mix of performance measures, including measures about process (e.g., training), outcome measures (e.g., absences from work) and 'strategic' measures (e.g,, safety culture)
>> incentives for senior management
>> regular reporting, including from internal and external sources, including benchmarking comparison (Ebbevi et a. 2021).

> **Limitations**: Qualitative; point in time; does not link to outcomes

Transferability to disability providers?

- Organisational size is typically smaller
  - Small numbers problem
  - Goal setting is possibly less meaningful (with the possible exception of medication errors)?
  - Fewer organisational resources available for quality and safeguarding?
- Greater diversity in operating models?
- Remuneration of directors?#
- Benchmarking of Q&S less common (Exceptions: AbilityRoundtable, MovingOn Audits)
- Outcomes more challenging to measure?

Beware institutional isomorphism

> The tendency of organisations in the same field* to adopt similar practices despite no evidence of their efficacy (DiMaggio & Powell 1983)

> Isomorphic forces

1. Coercive: legislation and regulation

2. Mimetic: For example, director with allied health background copying practices seen in healthcare

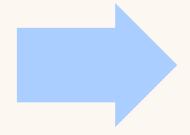3. Normative: Professional associations (e.g., Australian Institute of Clinical Governance) and consultants

A model of board influence on quality, safeguarding and safety

Boards of Directors

- Composition
  - Board size
  - Who is on the board
  - Skills
  - Training
- Structure
  - e.g., Q&S Committees
- Process
  - Interactions
  - Dynamics

→

Workforce

- CEO
  - Remuneration & incentives
  - Skills
  - Training
- Other managers
  - Skills
  - Training
- Workforce
  - Skills
  - Training

→

Quality, safeguarding & safety

- Quality and safeguarding processes
- Outcomes for people supported

PURPOSE AT WORK

To summarise ...

> Potentially, we can learn from other sectors (hospitals and health sector; WHS) about boards of directors and quality and safeguarding

> There is evidence from the hospital sector that board involvement in quality and is positively associated with improved Q&S outcomes and outcomes for people

> There might be lessons around board composition, structure and process

> There are reasons for caution about assuming transferability of findings

> We need research

> We need benchmarking

Purpose at Work

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