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Optimising health service board meeting processes and behaviours to better meet governance objectives

Briefing Document

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Optimising health service board meeting processes and behaviours to better meet governance objectives: Briefing Document

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Executive summary

Victoria has a devolved system of health service governance, in which local health service boards oversee health services on behalf of the Victorian Minister for Health. This involves a wide range of responsibilities including setting a clear vision, strategic direction and culture for the health service; actively leading quality and excellence in healthcare; understanding and managing risk; monitoring and benchmarking of performance; appointing a Chief Executive Officer; and delegating through them responsibility for implementing, monitoring and evaluating robust clinical governance systems.

Weaknesses in oversight of healthcare quality and safety by either the Victorian Department of Health and Human Services or the function of health service boards expose Victoria's patients to increased risk of harm. Sadly, these include catastrophic events such as the cluster of perinatal deaths at Djerriwarrh Health Services in 2013 – 2014. This led to a forensic examination of the systems in place that are designed to monitor and manage such risk across the state, led by Dr Stephen Duckett.

This research project, within the 3-year Victorian Managed Insurance Authority (VMIA) research and innovation program, focuses on *"Optimising health service board meeting processes and behaviours to better meet governance objectives*." This focus is the result of systematic prioritisation and consultation activities led by BehaviourWorks Australia in close collaboration with VMIA and DHHS. The results of the next step in this process - a rapid evidence and practice review – are presented in this briefing document.

The Duckett review contained 19 recommendations to enhance the skills, independence and effectiveness of health service boards, many of which speak to the operations of board meetings. The rapid literature review elucidated insights into board meeting behaviours, practices and decision-making processes. Relationships and group dynamics can have substantial negative impacts on board decision-making and function. Board chairs therefore play a critical role in harnessing the individual characteristics and insights that board members bring, as well as framing and driving a strategically appropriate agenda. The type and quality of information brought to the board is another central factor in determining how a board operates. Time, the meeting agenda, teamwork, cognitive decision-making processes and feedback on board function are further elements of importance.

Practice interviews with people who have deep experience and / or expertise in the Victorian health service board environment reinforced some recommendations of the Duckett report – in particular the importance of relationships within the board, the function of the board chair, information provision and the meeting agenda. Furthermore, these interviews revealed a range of other strategies including hospital walk-arounds, simulation of the patient experience, involvement of the wider hospital executive and independent governance evaluation.

Collectively, these inputs have generated an extensive suite of potential strategies to optimise health service board meetings. These will be the focus of a day-long dialogue that will deliberate upon the feasibility, scalability, relative importance and success measures of these options, with a view to a pilot trial in 2017 – 2018.

Aims

This research project is one of six to be conducted within a three-year Research and Innovation Program funded by the Victorian Managed Insurance Authority (VMIA) and being delivered by BehaviourWorks Australia (see Appendix 1 for more details). The research projects are developed using a structured approach known as the Forum method. The aim of this research project and the associated activities are presented below.

Table 1: Research Project Overview: Optimising health service board meeting processes and behaviours to better meet governance objectives

Aims	Status
Conduct a rapid review of evidence into the effectiveness of approaches to optimisation of board meetings, including within the health sector	Findings are presented in this Briefing Document, which has been prepared to inform a structured stakeholder dialogue at which research evidence is one of many considerations. The Briefing Document is directed towards stakeholder groups with expertise in or experience in Victorian health service boards. These include Victorian Department of Health and Human Services (DHHS), the Victorian Managed Insurance Authority (VMIA), representatives of metropolitan and rural health services and academic researchers.
Examine current practice and key issues in health service board meetings in Victoria through one-on-one interviews	
Convene a representative stakeholder group to: • Gain a shared understanding of evidence, practice and key issues in the Victorian Health Service Board sector; • Identify changes to health service board meeting behaviours or processes that could be trialled and scaled across Victoria; • Prioritise these interventions and determine how their effectiveness can be measured.	A day-long structured stakeholder dialogue will be held on **September 4, 2017.** The dialogue aims to connect the information from the briefing document with the people who can make change happen, and energise and inspire the participants by bringing them together to address a common challenge. This use of collective problem solving can create outcomes that are not otherwise possible, because it transforms each individual's knowledge to a collective 'team knowledge' that can spark insights and generate action addressing the issue. Specific questions for deliberation at the stakeholder dialogue are presented in this briefing document.
Design, develop, implement and evaluate a pilot trial of an identified intervention to optimise health service board meetings in Victoria	The pilot trial will follow the stakeholder dialogue in 2017 – 2018.

We used the following operational definitions to guide the work presented in this briefing document:

The function of **governance** is to ensure that an organisation or partnership fulfils its overall purpose, achieves its intended outcomes for citizens and service users, and operates in an effective, efficient and ethical manner (Langlands, 2004).

Good governance is about the processes for making and implementing decisions. It's not about making 'correct' decisions, but about the best possible process for making those decisions. Good decision-making processes, and therefore good governance, share several characteristics; accountable, transparent, follows the rule of law, responsive, equitable and inclusive, effective and efficient, and participatory (ESCAP, 2006).

Introduction

Why focus on board meetings?

High-quality healthcare has three defining characteristics – safe, effective and person-centred (State of Victoria, 2017). Delivering high-quality healthcare in first-world health systems requires the co-ordinated effort of a diverse range of organisations and individuals. A recently released framework on clinical governance published by Safer Care Victoria identifies seven key stakeholder groups who are involved in delivery of high-quality healthcare (Figure 1).

Figure 1: Clinical Governance Roles. Reproduced from *Delivering high-quality healthcare: Victorian clinical governance framework (June 2017)(State of Victoria, 2017)*

This research project focuses on the role of health service boards, and specifically on exploring opportunities to test and trial behavioural interventions at the level of the health service board meeting. The rationale for this is as follows:

- Governance was one of three high-priority challenges identified in a systematic prioritisation activity undertaken by BehaviourWorks Australia in collaboration with VMIA and DHHS in early 2017. The broad topic area identified in this exercise was "*Realising the potential of good governance in preventing harm, improving the patient experience and keeping per capita costs manageable*."
- A small expert panel including VMIA and DHHS was convened by BehaviourWorks to deliberate upon a more specific focus for the research project. This resulted in the topic *"Optimising health service board meeting processes and behaviours to better meet governance objectives*." In addition to meeting the research program criteria of being *behavioural, testable in the short term (under 6 months) and scalable,* the expert panel felt that while there has been a focus on *what* needs to change following several high-profile reviews in the sector, health service boards are wrestling with the question of *how* to enact the numerous recommendations for improvement.

- The Duckett review articulates 19 recommendations to enhance the skills, independence and effectiveness of health service boards, as well as recommendations pertaining to information, accountability, risk management and promoting a culture of safety and quality. These can be used as the basis for development of interventions at the board meeting level.
- A key related finding of the Duckett review was the need for health services to build stronger collaborations. This project offers the opportunity of harnessing good board meeting practices within some health services with a view to testing and scaling these across the system.

Composition of health service boards, recruitment strategies and remuneration were deemed out of scope for this research project. Although these are of critical importance to board function and effectiveness, they are not feasible to trial within the scope of this research program., Some activities (for example, new recruitment strategies for members of health service boards) are already being implemented at a whole-of-system level. Private hospitals were also deemed out of scope for this project as DHHS has a less substantial involvement in governance in this sector. However, it is recognised that the private hospital system provides approximately one third of hospital care in Victoria (State of Victoria, 2012).

An overview of current health service board structure and function in Victoria

The report by Safer Care defines the key responsibilities of health service boards as follows:

- "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" (Safer Care Victoria 2017, p. 8)*(State of Victoria, 2017)*

These responsibilities are discharged within the context of Victoria's devolved hospital governance structure. Whilst the Victorian Health Minister bears ultimate responsibility for the delivery of healthcare in Victoria, boards oversee health services on behalf of the Minister. Boards are responsible for appointing Chief Executive Officers (CEOs), who manage the day-to-day operation of the health service. A number of independent audit and review agencies such as the Auditor General and Health Service Commissioner provide additional oversight (State of Victoria, 2012).

Victoria has 22 large *Health Services* – metropolitan, major regional and denominational hospitals – and 63 smaller subregional, rural and multipurpose *Hospitals.* Board structure and composition varies between these two designations as summarised in Table 1.

Table 2: Overview of public health service and hospital boards in Victoria (from The Victorian health services governance handbook, 2012)(State of Victoria, 2012)

Type of health service (number)	Composition	Remuneration	Mandatory Committees
HEALTH SERVICES (22) • Metropolitan (13) and major regional (6) public health services • Denominational Health Services (3)	6 – 9 members; 3-year terms (max 3 terms)	Annual fee, reasonable expenses	• Finance • Audit • Quality • Remuneration • Primary care & population health advisory committee • Community advisory committee
HOSPITALS (63) • Subregional Health Services (9) • Local rural health services (11) • Small rural health services (36) • Multi purpose services (7)	6 – 12 members; 3-year terms (no max)	Reasonable expenses	• Audit • Remuneration

Health service boards do not have a mandated meeting schedule or quorum, but 75% annual attendance at board meetings is a requirement of board membership. All boards must develop a strategic plan with a 3 to 5-year horizon. An annual *Statement of Priorities (SoP)* consistent with the strategic plan is developed in collaboration between the health service and DHHS (and in the case of multi-purpose services, the Commonwealth) and made publicly available (https://www2.health.vic.gov.au/about/statements-of-priorities).

The SoP encompasses KPIs covering three broad areas – *access, financial performance* and *quality and safety*. A selection of weighted KPIs specific to each health service are developed which generate a *performance assessment score (PAS)*. A quarterly report against KPIs is reported to boards, and a monthly report sent to CEOs. The PAS and other performance inputs determine the extent of DHHS

monitoring for each health service. There are three monitoring categories – standard (performing acceptably against KPIs); performance watch (deterioration in performance against targets); and intensive monitoring (achievement against KPIs below 50/100). All health services submit annual and quality of care report to Parliament (State of Victoria, 2012).

Findings of the Duckett review relevant to health service boards

The Review of Hospital Safety and Quality Assurance in Victoria was commissioned following a string of perinatal deaths at Djerriwarrh Health Services (Bacchus March Hospital) in 2013 – 2014. Led by Stephen Duckett, the report was published in October 2016. In addition to failures of oversight by DHHS, a range of shortcomings in board processes and operations were also identified that extended beyond Djerriwarrh:

> *"Djerriwarrh Health Services was not special. It had fundamental flaws in governance that could happen anywhere" Andrew Freeman, CEO of Djerriwarrh Health Services (appointed October 2015; Duckett 2016 p. 9)(Duckett et al., 2016)*

A key finding of the Duckett report was that "Hospital care in Victoria is characterised by pockets of excellence, not consistent excellence" (p. 11)(Duckett et al., 2016) A range of deficiencies in health board knowledge, skills and activities were identified and include:

1. A lack of attention to quality performance as compared to financial performance, based on the belief that this was the domain of 'medical business'
    - 1 in 5 boards did not have quality performance as a standing agenda item (Bismark et al., 2013);
    - there was little formal quality performance training available, despite acknowledgement of its importance (Bismark et al., 2013);
    - half of the boards examined did not benchmark quality performance against external organisations – however all thought their performance equalled or exceeded that of a typical Victorian health service (Bismark et al., 2013);
    - *"All of these behaviours are an abrogation of the board's responsibility to hold the hospital executive to account for the safety and quality of care that it provides. Despite these many challenges, Victoria's health system governance arrangements still rely heavily on these boards to ensure our hospitals are providing safe and high-quality care. As such, there is a clear need to strengthen them. Consistent with the literature on boards and their impact on safety and quality, this review found that* ***gaps in board skills, information and oversight are a key priority for strengthening governance of patient safety in hospitals.*** *We recommend addressing these gaps through a more rigorous ministerial appointment process and better support to boards by the department, involving* ***improved information provision, training and clarification of role requirements****." (p. 27)(Duckett et al., 2016)*
2. Inadequate clinical representation on boards, despite evidence that clinical representation can enhance patient and financial outcomes, and inadequate *meaningful* (rather than tokenistic) consumer representation
3. Insufficient information provision, with the annual report being one of the only sources of comprehensive information about care delivery

- *"the hospitals that need the most support in terms of external benchmarking and comparative data have the least access to it"* (p. 39) (Duckett et al., 2016)

4. Inadequate resourcing of in-depth case review in rural hospitals due to discontinuation of the Limited Adverse Occurrence Screening (LAOS) program
5. Poor collaboration between health services:
   - *"A health service that acts in isolation from the system and believes they can manage their patients without the need of external support underpins the tragedy of the events and what has followed at [Djerriwarrh]. Expertise, assistance, and resources were less than 40 minutes away." Dr John Ballard, Administrator, Djerriwarrh Health Services (p. 44)* (Duckett et al., 2016)
6. Inadequate accountability of clinical leaders
7. Tension in rural boards between the need to retain part-time clinicians (Visiting Medical Officers (VMO's)) who attract funding for services and address inadequacies in such services by holding clinicians to account
   - *"Visiting Medical Officers in small hospitals have more power than CEOs and Boards because they can withdraw services. In some cases this means that the hospitals can't remain open. For example in one hospital, a VMO threatened to leave if a mortality and morbidity structure was initiated. The structure did not progress. CEOs and Boards of small hospitals have almost no control over the procedures that are performed, even if they are not safe. Anonymous submission (p. 50)* (Duckett et al., 2016)
8. Lack of a reporting culture regarding adverse events, as underlined by *"consistently and unusually low rates of mandatory notifications compared to other jurisdictions"* (p. 63) (Duckett et al., 2016)

Opportunities for change at the board meeting level

The Duckett report highlights a range of evidence-informed behaviours that could be harnessed in a local trial. Some of these are highlighted below:

> *"The skills, work and leadership of boards matter. International research shows that* ***when boards are actively engaged in their hospital's quality agenda, the hospital is more likely to have quality improvement programs in place, and more likely to be performing better on a number of indicators****. Higher rated boards are associated with more effective management, which is associated with higher quality care. In particular, boards that pay more attention to quality of care and use clinical quality metrics more effectively tend to have managers that perform better at monitoring quality performance, setting targets and managing operations.*
>
> *Boards also have an important role to play in setting the tone for organisational culture. A recent, large-scale study of boards in the United Kingdom's National Health Service found there was* ***a significant relationship between a board's governance activities and competencies, and whether staff felt safe raising concerns about patient safety issues and were confident that their organisation would address them****. This suggests an important role for boards in encouraging internal whistleblowing, and thereby guarding against catastrophic failures in care. This role is important, given that the bulk of Australia's major hospital safety scandals have been brought to light through whistleblower action, and that greater internal and external attention to the*

concerns raised by nursing and midwifery staff at Djerriwarrh would have led to much earlier discovery of the service's problems. (p. 51)(Duckett et al., 2016)

In considering the influence that a health service board can have on organisational culture, it is also important to reflect on how embedded practices and thinking can influence the culture and practices of the board itself.

"while local decision making is a good thing in principle, it relies on the capability of the decision-makers and the information they have available. Weak performance assessment and local information systems, combined with rhetoric about devolution, can create a situation where no-one feels they are responsible for quality and safety" (p. 67)(Duckett et al., 2016)

The remainder of this briefing document examines research evidence pertaining to interventions designed to optimise board meetings, and explores current board meeting practices and issues in the Victorian health sector.

What does research tell us about effective strategies to run board meetings?

A rapid literature review was undertaken to identify, evaluate and synthesise published literature investigating principles and strategies to run effective board meetings, including sub-committee meetings. Whilst a focus on health service boards was prioritised, evidence from other disciplines and general board meeting principles were also considered.

Rapid reviews are an emerging method of efficiently synthesising research evidence in health policy and other settings where a broad overview of research evidence is required in a short timeframe. Unlike traditional systematic literature reviews (which take 12 –18 months), rapid reviews focus on synthesised research evidence and / or high-quality or recent primary studies. *Caution needs to be applied interpreting rapid review findings, as more comprehensive review approaches may elucidate further information and insights, which would influence review interpretation and conclusions. Therefore, systematic reviews remain the definitive method of literature review, and we recommend systematic reviews be undertaken whenever possible. Further details of the review and other methods employed in producing this briefing document can be found in Appendix 2.*

The literature search yielded a total of 1143 citations. Following screening, only one narrative review was identified. This review has been supplemented where appropriate with additional evidence from 27 primary studies, due to the dearth of relevant review-level literature identified. However, the primary studies were not quality appraised and therefore should be interpreted in this context.

The results are presented under two main headings: Board Meetings and Board Members; and Cognitive and Group Processes.

Board Meetings and Board Members

Understanding board meetings

Corporate governance institutions, such as boards including health system boards, can be primarily conceived of as problem-solving institutions that reduce complexity, create accountability and facilitate cooperation and coordination between stakeholders (van Ees et al., 2009). However, Boards do not always operate to their best ability. Prybil's (2008) study of CEOs' perceptions of their healthcare boards found that less than 50% of boards review core governance processes regularly, recruit new members based on expertise gaps, recognise the importance of board education or hold board members to high standards of performance (Bennington, 2010; Prybil et al., 2008).

Much of the literature that has investigated Board meetings traditionally utilised Agency Theory, which posits that professionals will seek to pursue their own interests under conditions of asymmetric information rather than meet broader organisational objectives (Mannion et al., 2017; van Ees et al., 2009). This approach has been criticised for its limitations and in recent years there has been a stronger focus on understanding the behaviour and attitudes of board members in the literature. For example, group decision process theory focusses on how information is processed and managed in Boards, the ways in which information influences group decisions, and the group decision-making dynamics that underlie those decisions (Brown, 2005). Such theories may encompass procedural aspects (e.g. how information is processed and presented), cognitive aspects (the skills and

interpretative work required to make sense of data) and social aspects (e.g. how a multiplicity of voices are accommodated into complex decision making) (Mannion et al., 2017).

Relationships and roles within governance boards

The relationships within a governance board can have important implications for how board meetings unfold (note that teamwork will be discussed separately). There are both formal and informal practices within Boards and Board meetings. Many problems highlighted by the literature occur within the informal sphere of the board, such as information asymmetries between management and directors, relational difficulties and tensions, and a lack of open boardroom discussions (Peij et al., 2012).

Furthermore, informal power dynamics and alliances can influence how board meetings run. Such informal networks within boards influence the decision-making processes. Dominant members may form an alliance of like-minded individuals who then set the tone for how decisions are made. However, this may not be conducive to well-informed decisions. Outside or independent members can bring required objectivity to the meetings, however these independent members can be powerless if they are on the periphery of the informal social networks of the board (Stevenson and Radin, 2015). The importance of open and transparent dialogue within board meetings therefore becomes paramount. Research into leadership communication supported fostering trust within the team with the aim of keeping communication lines open (Fairhurst and Connaughton, 2014)

Maharaj (2008) identified different types of 'functional board members' that can play different beneficial roles within a board meeting. The first of these, 'Challengers' ask tough questions - questions framed in a constructive way that can progress the discussion, rather than detract from the discussion with criticism. 'Counsellors' act as coaches to other board members. They have good knowledge of contextual information that can help board members make informed decisions and are therefore able to foster a more informed discussion. 'Consensus-Builders' use conflict-resolution skills to ensure that there is sharing of information. By learning about the needs, expectations and motivations of directors, organisations can ascertain whether the values of directors are congruent with the organisation (Maharaj, 2008). Understanding the different roles that can be played by Board members can help utilise skill sets more effectively to enhance discussion and the decision-making process.

The Board Chair

The Board Chair holds a special position within the Board. Their role can be central to running an effective board meeting. Empirical evidence from corporate governance suggests that effective board chairs "provide control around the board's agenda; bring relevant issues forward; create a culture of give and take that allows for dissention and the asking of difficult questions; are inclusive; and freely share information" p.414 (Harrison and Murray, 2012). Effective chairs are proactive in their roles, they interact frequently and actively clarify and redefine issues making them easier to understand.

The benefits of having an independent chair include that the board has a clear leader whose major mandate is the effective functioning of the board itself (Conger and Lawler Iii, 2009). However, a study of non-profit board chairs (including hospitals) found that 64% thought their role was to keep the board's focus on the organisation's strategic directions, 49% to ensure the board fulfils its governance responsibilities and only 42% to preside over and manage board meetings (Freiwirth et al., 2016). Thus, there is a gap between the role of an effective chair and the perceptions that board chairs have of their responsibilities.

In a study of Boardroom group decision-making, Another study found that the chair's role was crucial in being responsible for controlling the meeting through encouraging and structuring healthy debate, as opposed to making decisions (Edlin, 2005). The research findings suggest that the effective chair is seen as a facilitator who contributes to organisational effectiveness by building social cohesion and commitment in their interactions with CEOs, stakeholders, and the board as a whole (Harrison and Murray, 2012). It also puts someone in charge of board meetings whose primary role is getting the board to make good decisions (Conger and Lawler Iii, 2009). This can result in better information availability, better decision processes and more committed boards.

The best Board Chairs recognise that some of their directors are quieter than others and that the discussion on certain topics will be dominated by those who either are very vocal, have a background on the topic or are otherwise experts. To establish a norm that all board members' perspectives are valuable, the act of polling implies a concern for the perspective of the collective or team (Conger and Lawler Iii, 2009).

Information provided to the board

Boards cannot make good decisions without adequate information. As described above, the Duckett Review reported a 2012 survey of Victorian boards in which virtually all respondents believed that the overall safety and quality of care delivered at their health service was as good as, or better than, the typical Victorian health service. This self-assessment bias reflected a lack of benchmarking data, which meant that many hospitals did not actually know how the safety and quality of their care compared with other hospitals' performance.(Duckett et al., 2016)

The type and quality of information provided is central to how boards understand issues and how they will make decisions. However, some boards receive insufficient or poor-quality information and others are unaware of the type of information they should be requesting. A survey of corporate boards found that almost half (47%) reported inadequate information provided to the supervisory board by executive directors (Peij et al., 2012). The information supplied was not always based on the needs of the directors, or too much information was provided without adequate context. In this study, the quality of information was deemed sufficient but was provided too late (Peij et al., 2012).

Improving the diversity and quality of data sources can also help inform the board (Walton, 2009). Walton (2009) recommended that Boards use tools to synthesise and prioritise information; this could be through committees or tools such as scorecards.

A final consideration is the information processing demands on board members. When information processing demands on corporate boards are too high, they become less effective and are less able to make good decisions (Boivie et al., 2008). Thus, in situations where the cognitive load of information processing is high, efforts to reduce this should be explored.

Time and agendas

In order to make good decisions and lead effectively, boards must have the time to discuss important issues. The frequency of Board meetings varies across organisations, but one study found that public hospital boards in the United States tended to meet around 16 times per year (Bennington, 2010). Hospital boards tend to meet more often than boards in the business sector, with almost half of hospital boards (48%) meeting monthly or more. Hospitals with less than 100 beds and those in rural locations are more likely to meet monthly or more frequently than larger hospitals or those in urban locales (Bennington, 2010). Other studies have revealed that the proportion of the time spent on the

different issues differs substantially across healthcare boards. Prybil (2008) found that boards devote close to 25% of their time to patient care, quality and safety issues; about 25% of their time on financial issues; about 10% of their time on board development (succession planning, recruitment, education, evaluation etc.); around 7% of their time on CEO performance evaluation; and about 25% of their time on strategic planning issues (Prybil et al., 2008). In contrast, a study suggested that most believe strategic discussions should take 40-60% of time while American hospital and healthcare boards were found to spend around 32% of their time in this area (Bennington, 2010). In another study, although 75% of CEOs reported that nearly most of their board meetings have a specific agenda item dedicated to quality, only 41% reported spending more than 20% of their time on items related to quality (Jiang et al., 2008). In this same study, although 65% of the respondents said that the board is involved in setting the quality agenda for the organisation, less than half of the respondents reported that the board is also involved in setting the agenda for the board's discussion on quality (Jiang et al., 2008).

The role of quality sub-committees becomes important in the context of restricted time in Board meetings. Of boards with a quality committee, 91% used quality dashboards or scorecards, compared with 79% of boards without a quality committee. Boards with a quality committee were more likely to include indicators for clinical quality, patient safety, and patient satisfaction, as well as national benchmarks in their quality dashboards or scorecards. However, no significant difference was found between boards with and boards without a quality committee in how frequently board meetings include quality on the agenda and how much board meeting time is devoted to the quality item (Jiang et al., 2008).

Time is also an important factor in-group performance and is often central to structuring group discussion. Groups under greater time pressure provide lower quality outcomes across a range of control and advisory tasks (Pugliese et al., 2015). In their study of two corporate boards, Pugliese found that board members' awareness of time pressure played a great role in either helping or hindering member inclusiveness during the discussion (Pugliese et al., 2015).

Cognitive and Group Processes

Decision-making

Decision-making is clearly central to a Board's responsibilities and has a significant impact on the effectiveness and outcomes of a Board.

Literature on group decision-making distinguishes two categories of decisions: intellectual tasks; those that have a demonstrably correct answer; and judgemental tasks, where alternatives are presented and consensual agreement must be reached through a process of dialogue (Edlin, 2005). When a consensus must be reached, it implies that each member of the group is explicitly aware of the trade-offs, negotiations, and game-plays that take place as members consider their position and ideally modify their decisions according to the quality and weight of information and arguments presented (Edlin, 2005).

An investigation into group decision-making by Edlin (2005), found that information provision and information gathering were the key contributors to effective decision-making in board meetings. In a group scenario, as information is presented, debate pivots around understanding and testing ideas which provides a mechanism for gathering additional information relevant to the discussion. This process of investigation and clarification not only identifies alternative options but also highlights why some solutions are more suitable. This information sharing/gathering process acts as a filter for the

information and from it a consensual decision is arrived at – one that all board members can take ownership for.

In some circumstances, during this information sharing and discovery process, if a member expresses a strong argument against the majority of the group, pressure may be exerted on that member to convey that dissent is contrary to what is expected of loyal members (Maharaj, 2008). The result is that the group inadequately surveys alternatives and objectives. They fail to examine the risks attached to preferred choice. The group may be unable to reappraise initially rejected alternatives, resulting in poor information search, selective bias in processing information at hand or even failure to work out contingency plans. Therefore, increasing the level of participation among board members at board meetings can be used to reduce the negative effects of groupthink (Maharaj, 2008).

Decision-makers in organisations experience limits in their ability to process information and solve complex problems. Studies have shown that applying rationality to complex problems has a steep cognitive cost. Board members cope with uncertainty by complexity-reduction and by routinely simplifying and structuring information through their perceptual filters and pre-existent knowledge structures (van Ees et al., 2009). Board members mainly recognise familiar information as more relevant, so they are biased to give this information more weight in their decisions. However, such decision-making short-cuts by no means guarantee the best possible decisions and may be susceptible to bias. The previous experiences of board members, their expectations and reference groups, as well as their routine procedures for information processing and learning, are highly relevant for our understanding of board decision-making and the limited information boards must cope with (van Ees et al., 2009). Having some distance from the operations or regular information of a hospital may actually increase the scanning effectiveness of board members (Rindova, 1999). This reflects the recommendation in the Duckett report to enlist the input of an independent clinician into examination of the quality of care in health services (Duckett et al., 2016).

It is often assumed that decision-making is a linear process that is performed sequentially. Possible options are presented and board members select from those options, the chosen option is put into practice and members evaluate the outcomes. In reality, strategic decisions evolve through complex, nonlinear and fragmented processes. As a result, decision tasks are seldom rationally divided and sequenced as the agency model assumes (Rindova, 1999). Studies of decision-making in realistic settings suggest that decision makers focus more on understanding the situation by means of constructing and elaborating mental representations than on evaluating the merits of alternatives (Pettersen et al., 2012).

Unstructured or fragmented decision-making processes can lead to narrow accounts and potentially inconsistent actions. Conversely, guided decision-making processes with stronger leadership and member involvement lead to a more unified outcome (Sur, 2014).

Working in teams

Boards are, by definition, teams of people who come together to make group decisions. The dynamics within these teams play an important role in how those decisions are made. The board meeting is the primary setting in which the entire board interacts as a group, and therefore the arena in which directors develop norms about their team identity and process. Directors bring very visible external identities (e.g. professions, positions), which may have been why they were selected to join the board. As a result, members may arrive with a clear notion of where they will make their contributions. For example, the banker expects to contribute on financial issues. Such narrow role

definitions promote an individual identity rather than a team identity. It is often the responsibility of the Board Chair to simultaneously harness each member's special expertise and encourage them to contribute to a broader set of issues facing the board. The Chair's leadership task is to make certain that members' contributions do not become too narrow leading to the reduction of a set of experts who speak only on their individual topics and who do not operate as a team.

Although boards do not spend extensive periods of time together, they can develop a routine that is built up over time (van Ees et al., 2009). Routines can be understood as the codified memory of the organisation, embodying the past experience, knowledge, beliefs, values and capabilities of the organisation and its decision makers. Routines conserve the cognitive abilities of board members and serve to channel and limit conflict among them. Alternatively, they direct attention to selected aspects of identified problem situations (van Ees et al., 2009).

Compared to most working groups, board members spend relatively little time together as a total board. They typically meet in person for a day or two, six to ten times a year with gaps of weeks between meetings. There are often phone calls and email communication among board members, but the board as a whole simply doesn't spend much time operating as a team. This lack of time together makes it hard for members to develop a genuine sense of team identity and to learn how to operate as a team (Conger and Lawler Iii, 2009).

Cognitive conflict is common in teams. This refers to disagreements about the content of the tasks being performed, including differences in viewpoints, ideas and opinions (Forbes and Milliken, 1999). Cognitive conflict is actually an important ingredient in effective group task performance (Heemskerk et al., 2015), while relational conflict (e.g. personality clashes or negative interactions) between members detracts from effectiveness. Cognitive conflict positively influences group performance by increasing understanding and critical evaluation of task and ideas and challenging confirmatory biases. It has further positive influences on commitment and satisfaction as group members can voice their own opinions. The independence of view which is essential for cognitive conflict can only be created in a group that values dissent and handles conflict productively (Walton, 2009). Debate helps board members assimilate individual knowledge into collective understanding (Walton, 2009). Having structured protocols can help not only synthesise and interrogate information, but can also create etiquette for the boardroom that allows permission to challenge. Furthermore, a protocol or question list puts the onus on members to explore information (Walton, 2009).

Another challenge in a team setting is time allocation for varying viewpoints. In a study of two corporate boards, it was found that a single participant accounted for around half of all speaking time in any one item, and the top-3 contributors accounted for more than 80% of the speaking time (Pugliese et al., 2015). Often the information that boards receive and need is so specialised that only a board member with an in-depth technical understanding can explain it. In these cases, boards need to operate as a sounding board for those with the right expertise and integrate data from other areas (Conger and Lawler Iii, 2009). This inherent asymmetry of information results in one participant who provides most of the input and gains a central position in the discussion of the specific agenda item. Subsequently a small number of directors will share the remaining discussion time debating the issue with the main contributor (Pugliese et al., 2015). This creates a challenge in ensuring a varied and in-depth discussion of the issue and its options occurs.

Board evaluations can play a role in assessing how boards operate as a team. In order for board evaluations to be effective, at the start of the year, the board should set objectives for teamwork and

shared leadership (Conger and Lawler Iii, 2009). For example, there may be objectives set for different directors to assume a leadership role on certain topics or an objective for breadth of participation at meetings. Both qualitative and quantitative surveys can be employed at the end of the year or for a particular matter during the year to gauge the quality and extent of teamwork. A quantitative survey might not only assess the degree of teamwork, but also the degree to which leadership rotates across the board, the quality of a collaborative decision-making process, and the degree to which directors listen to one another (Conger and Lawler Iii, 2009).

Key aspects of teams are the norms that are established within the groups. For Boards, one of the central norms relates to effort. Effort norms are a group-level construct that refers to the group's shared beliefs regarding the level of effort each individual is expected to put toward a task (Forbes and Milliken, 1999). A board where demanding norms that are shared by all members exist on the effort that is expected of its members will fulfil both its control and its advisory task more effectively (Heemskerk et al., 2015).

The development of an 'inner board' (a subset of board members with high influence) that grows among some of the board members outside of the board room is likely to have profound effects on information, cognition, and decision-making. Research has found that informal networks developed within boards, and these networks, partly shaped by the formal governance structure within which they were formed, had effects on cognitive agreement within the board meetings (Stevenson and Radin, 2015). These informal networks reflect a cognitive similarity and an ability to influence others on the board. Those who were linked in these informal networks were more likely to agree on the information leading to a decision. Those outside of these informal networks were less informed and had less influence (Stevenson and Radin, 2015). From a behavioural point of view, uncertainty and a lack of formal procedures for making decisions leads some members to create an informal structure of ties to reduce uncertainty and develop a shared perspective (Stevenson and Radin, 2015).

A study which investigated the effect of procedural structure on group dynamics and performance found that procedural structure increased equality of participation by reducing the groups' overall conversation level. It further reduced the number of comments made by the dominant member and affected the range between the most dominant and quietest group members, but not the overall variation in comment level among the group (Hacker and Kleiner, 1999). This research also found that the best predictors of group performance were the number of comments made and the range in the number of ideas contributed by the most and least frequent idea contributors (Hacker and Kleiner, 1999).

Feedback

Feedback has been used in many circumstances to help teams understand how they operate and improve. One study investigated an intervention which, through the use of trained observers, provided groups with interim feedback on their rational and interpersonal processes (Kernaghan and Cooke, 1990). The rationale for intervening in group processes assumes that a group's performance, whether effective or ineffective, is a function of both the attitudes of group members toward group potential and their shared perceptions of what constitutes appropriate member behaviour. Positive interpersonal behaviours would include active listening and clarifying by group members, supporting and building upon others' opinions and discussing differing views with other team members (Kernaghan and Cooke, 1990). The productive use of rational group resources would involve analysing the situation, setting objectives, developing alternative courses of action, identifying obstacles and

consequences, and making final decisions. The objective of most group training interventions is to reinforce the aforementioned positive behaviours. Interpersonal feedback by itself did not improve group output in planning. The effects of rational feedback were dependent on whether the group was high-ability or low-ability; the high ability groups benefited significantly from feedback concerning the nature of their rational processes, while the low ability groups showed no positive effects. Rational feedback therefore did have a positive effect, but only for those groups possessing the requisite skills to make use of the feedback (Kernaghan and Cooke, 1990).

A review of team-level feedback found that it might be most effective in cases of task and team interdependence, where team members are prone to affiliate with other members, when the goal of the feedback giver is to impact attitudes towards the team, members' attribution of performance to the team and reduce disagreement among team members (Gabelica et al., 2012). With reference to feedback type, it seems that process feedback (defined as information regarding the way one performed a task and reached expected results) has an effect on team functioning, learning, and members' satisfaction, while feedback on outcomes and results appears to improve performance. In practical terms, it appears that feedback intervention effectiveness might be improved if feedback is accurate, given in a timely manner, regular, non-threatening, shared, given directly to teams it targets, and when its distribution is fairly equal (Gabelica et al., 2012). Positive feedback was generally shown to be positively linked to performance and team process variables. However, despite its potential detrimental effect on members' affective reactions, unfavourable feedback does not always bring negative outcomes, it may actually produce some motivational positive effects (Gabelica et al., 2012).

What can we learn from the experiences of Boards and subcommittees?

Practice interviews were conducted with six participants; one CEO, one Director of Quality and Safety, two Board Chairs and two Board Directors.

Engaging Board members in quality and patient safety

The interviewees confirmed that it is crucial to engage board members in issues of patient safety. Involving board members in walk-arounds of the hospital was reportedly useful and helped board members identify and understand concerns and issues on the ground, as well as providing insight into what could be improved. This type of engagement gives board members a better perspective of hospital issues. However, it was recommended that this should be a separate event from safety walk-arounds. It's important to maintain the depth of questioning that occurs in the normal safety walk-around, ensuring that Board members do not become a distraction.

> *"The walk-arounds, I think they both give you a chance to see how parts of the hospital work, and there's nothing better than actually seeing what's involved…But also from the hospital's point of view, they're seeing board members come to see them."*

> *"I think initially they were introduce as a way, like a safety walk around, it was meant to be members of the executive and some of the clinical directors would attend areas other than their own just to see if there were issues with the staff brought up that were of concern to them…I have to say I think that having the board members changes the perspective of the walk around a little bit because the board members are also doing a bit of a, it's almost like a bit of a tour cause they're not as familiar with the operation of the hospital"*

Such walk-arounds can be a useful opportunity for Board members to ask important questions.

> *"So we have a couple set questions that we ask you know, "What's working well? What's not working well? And what do we need to improve? And how can we make it safer? Is there anything that you are concerned about from a safety perspective either for the staff or the patients?"*

Beyond walk-arounds, another way to improve question asking was to have clinicians on the board who could ask the right type of questions, and who could help the executive or presenter reinforce the importance and relevance of the information being provided. However, another interviewee argued that the right type of clinician must be found, as they need more than just clinician skills.

> *"But, there's a lot of clinicians that would not necessarily contribute to that board or picture at a board level. So, it's more than clinicians. It's clinicians that have got literacy in this space."*

Interviewees reported that it is now common to share patient stories at the start of board meetings. Other strategies to provide insight into patient experiences included recreating experience for board meetings (e.g waiting in the waiting room, sitting on the floor while waiting, putting on a patient gown, sitting in stirrups in a maternity hospital).

> *"We have a programme called Creating Exceptional Experience that our staff are all going through and I think some of our board member have gone through so and as a part of that programme, which is a five-week programme you need to put yourself into a patient's shoes. So you do something like go sit in the waiting room or basically we've got people who have been lifted on a hoist or people who*

have been put up in stirrups just to see how does that make you feel? Or even changing into a gown, how does that make you feel? It increases your vulnerability."

Relationships within the Board

Establishing the right atmosphere to a board meeting is key to the board being able to achieve its objectives. In some instance, this can be challenging with new board members. To set up the right atmosphere for new board members and to allow them to ask questions and become acquainted with the processes of the board, one health service is exploring setting up a 'Buddy System' where new members are paired with more experienced board members.

> *"I think, one thing that we didn't do a lot of in the early days was actually spend much time in committee, and we sort of started to do that on a more regular basis now with, we've got a reasonable level of new board directors, so we got quite a number of new board directors started recently. We talked about having a buddy system almost. We haven't formalised any buddy system as such, but just making sure that there's someone sitting with the new directors to ensure that if during the meeting, if there's something they're not sure of…just to have someone beside them that's been around for a little while that they can just confirm and just say, "Is my understanding right here," or having that openness and contact with either the board chair or any other board member to speak to after the meetings if they want to clarify any points."*

Having the executive team attend board meetings was seen as highly beneficial; questions can be asked directly to the executive or director responsible for that area. It also allows for a more streamlined process in feeding information back into the organisation, as not everything goes though the CEO.

However, one service reported that when executives started attending board meeting they were reluctant to discuss issues or problems. Building trust and an open dialogue was central to open the discussion between the board and the executive.

> *"In the early stage, they're [the execs] pretty loath to talk about any issues because I think they thought, Geez, what's going to happen here. But now they are getting more confident that they do just open up and say, well this is what the good things but these are the bad things that's happened and this is what I did to change it or improve things."*

The Role of the Chair

The Chair plays a central role in managing the board meetings and its members. Thus, it is important for the Chair to get to know the members, their work styles and their strengths so that they can bring them out where appropriate.

> *"That is really one of the key parts of the board chair's role, is to make sure that the discussion is focused. That the discussion is robust, when it needs to be robust. That everyone gets an opportunity, when the discussion gets off track, that it's brought back to the point fairly quickly."*

The importance of fostering relationships within the board was emphasised, particularly the role of the Chair. The Chair spending time getting to know new board members and discussing their concerns, meeting with members prior to the board meeting to gauge if there were any issues that needed to be discussed and providing opportunities for all members to have a say during the meetings was viewed as critical. As reported by a Board Chair:

"At the end of the meeting, I always go around to each of the directors and ask them, are there any strategic considerations that we haven't talked about that you would like brought forward to the next board meeting and discussed?."

The Board Chair is central to establishing an atmosphere of open and transparent dialogue; they set the tone of the meeting. One Board Chair reported that they thought it important that they only express their own view at the end of the discussion after allowing all members to speak, so as not to set the direction of the discussion. To assist the Chair, having an outside or independent board member (someone who does not have strong relationships with the health service or other board members) can also add a helpful perspective that oversees and reviews the process of the board meeting.

Information provided to the Board

Information and data are key to a functional board. Information provides a line of sight into the organisation.

"what's reported to us is like a series of thermometers that you put into different parts of the organisation"

However, interviewees emphasised that this Information must be contextualised. For example, what is sent out from DHHS can be too much information and lacks the contextual information that would make it relevant for the health service and for the Board to interpret. The Information provided needs to have the 'so what' factor i.e. why is this relevant for the board:

"I think they are sending out too much now and it's not correctly filtered. It doesn't have context around it. The board members get reporting straight to them, which is fine, but it doesn't have the hospital context around it."

More consistent information/data standards would help the Board understand the relevance and meaning of information. Information and data should also be used for bench-marking across the state and allow for health services to compare themselves to similar health services. For example, a template of baseline/minimal data set that boards should be viewing.

"I think that there hasn't really been a kind of cogent suite of the elements that go to make up clinical governance, required of boards, or presented to boards in a way that they're required to make sure that they have those things in place... Importantly, they have to have a framework in place that ticks the boxes. So, they need to have a framework constructed that is solid, and comprehensive, and looks at all of the elements of clinical governance."

Beyond having the right framework in place, one interviewee stressed that Board members needed tools and ways to measure what they were doing. The Board needs to know if the health service is doing things it shouldn't be doing, if people (patients or staff) are at risk of harm.

"It's about, if I'm on the board I'd want to know, "Is this hospital practising safety, are there things that we're doing that are putting people at risk? Either staff or patients."

"So, some form of dashboard, or reporting suite that provides high level indicators which are absolutely valid. And which have a high level of kind of, internal integrity, is really what's necessary."

Reviewing information from across the organisation is central to the board being able to make good decisions. But there are challenges in the best ways to get this information to the Board.

"to get good information that's not filtered through too many layers. So we would get ... Quality and Safety Committee has a regular meeting with the senior medical staff and the senior nursing staff.

They have a number of presentations that we work through the year on from different clinical units in the hospital."

"Broadly, what is it that the board needs to know that gives them assurance that we have the appropriate systems and processes in place to provide high quality care and to address any issues that arise. So in some respects, as a board member that's what you are looking for."

Sharing information across the board and sub-committees of health services could improve understanding of what information is available, what others have access to, and what questions are being asked in other areas. This could improve information consistency across the whole health service; making it easier to relay what the Board hears throughout the hospital.

"I think it would be good to not just provide that information to the board but to say to organisations, "Here's some sort of-", I'm just making this up so don't take this gospel clearly, if there was some kind of baseline template that said you know, "This is the minimum data that you should be reporting to your board and I think that would help the board members"

The information the board reviews should be linked to strategic objectives and strategic plans. For example, putting a heading above specific agenda items about how they relate to strategic objectives. Following this, all options should be put on the table and alternatives discussed. The Board members should be encouraged to ask questions such as; "what do you mean by that?"

Asking interrogating questions of the information presented is the key skill of board members.

"So given that you are reliant in every respect on the information that's coming to you, is knowing when to ask questions about it. Knowing when to dig, when, in a sense, that an explanation is sufficient…[the problem was] that people didn't know what questions to ask because there was a lack of clinical background on the board."

Board self-assessments or evaluations can also increase their knowledge base and identify gaps that need to be addressed. Tools to evaluate governance have been used effectively to help boards reflect on their practices, for instance, Boards reflecting on the effectiveness of the Board Chair's role.

Time and Agenda

A structured and focused agenda was raised by interviewees as a crucial aspect to running effective Board meetings. The agenda should be strategically focused and have standing items relating to quality and patient safety. One interviewee reported that this should be the first item on the agenda for every board meeting.

"I think the critical thing is to make sure that your agenda is strategically focused."

"we've tried to restructure the papers, in such a way to actually link it back the strategic plan."

It is important that all members get an opportunity to speak during Board meetings and a structured agenda can help facilitate this. The agenda should also outline decisions that need to be made as this can help focus discussions.

Some boards, including those of smaller health services, may get caught up in the operational detail and the day-to-day activities of the health service and dedicate less time to strategic issues. Therefore, a focused agenda may be particularly beneficial in these circumstances.

Possible strategies to optimise board meetings identified from the evidence and practice review

The Board Chair

- Calling on directors (e.g. to call out particular expertise or raise a concern) (Conger and Lawler Iii, 2009)
- Polling the board (Conger and Lawler Iii, 2009)
- Go around the room sequentially to gain input from all members (Conger and Lawler Iii, 2009)
- Having pre-meeting conversations with directors (Conger and Lawler Iii, 2009)
- Fostering conversations between directors (Conger and Lawler Iii, 2009)
- Clarify the relationships and responsibilities of the Board Chair (Freiwirth et al., 2016; Harrison and Murray, 2012)
- Regularly evaluate the leadership effectiveness of the Board Chair (Harrison and Murray, 2012)
- Provide development opportunities for the Board Chair (Freiwirth et al., 2016; Harrison and Murray, 2012)
- Develop a succession plan for board leadership (Freiwirth et al., 2016; Harrison and Murray, 2012)
- Provide more accessible and research-based resources for board chairs and capacity builders (Freiwirth et al., 2016)
- Include the executive at Board meetings (from Practice Interviews)

Agenda

- Involve members in setting the agenda for the board's discussion on quality (Jiang et al., 2008)
- Allocate appropriate share of board meeting time to the quality items (Jiang et al., 2008)
- Colour-code agenda to evaluate how much time is dedicated to key priorities (Moore, 2010)
- Use the question "So that…?" to determine the true intention of an agenda or agenda item (Pearl, 2013)
    - Can also be used to interrogate other sources of information
- Block out more time for specific agenda items that require in-depth discussion (Jiang et al., 2008)
- A strategically focused agenda (Practice Interviews)

Information

- Establish committees to digest and make sense of information (Walton, 2009)
- Utilise scorecards (Walton, 2009)
- Reduce information processing demands (Boivie et al., 2008)
- Actively evaluate merits of alternatives (Pettersen et al., 2012)
- Establish templates for questions that need to be asked or how to interrogate the information provided (Practice Interviews)
- Provide relevant context of information for the Board (Practice Interviews)
- Establish benchmarks or templates for minimal data requirements (Practice Interviews)
- Link information to strategic objectives (Practice Interviews)

Education

- Improve the quality literacy of board members (Jiang 2008)
- Formally outline protocols of inquiry (Walton, 2009)
  - E.g. one board developed five standard and straightforward questions for every big strategic decision: Does this fit with the strategy? What is the cost of not doing this? What are the alternatives? What are the unseen risks? Who would oppose this?
- Use tools to evaluate and reflect on practice (Practice Interviews)

Teamwork

- Achieve alignment on quality initiatives among key stakeholders in the organisation (Jiang et al., 2008)
- Practice productive debate (Walton, 2009)
- Set a buddy system for new board members (Practice Interviews)
- Utilise structured group decision-making processes (Sur, 2014)
  - Decision making aides
- Establish 'effort norms' for engagement with material and commitments (Heemskerk et al., 2015)
- Enable cognitive conflict for tasks where conflicting viewpoints help to investigate a topic. Discuss conflicting perspectives (Heemskerk et al., 2015)
  - Utilise Six Hat thinking
- Set objectives for different directors to assume a leadership role on certain topics or an objective for breadth of participation at meetings (Conger and Lawler Iii, 2009)
- Set targets for the number of comments by all board members (Hacker and Kleiner, 1999)
- Assess use of Board members' knowledge and skills (Forbes and Milliken, 1999)
  - E.g. "people on this board are aware of each other's areas of expertise," "when an issue is discussed, the most knowledgeable people generally have the most influence," and "task delegation on this board represents a good match between knowledge and responsibilities."
- Engage board members in patient safety through experiences (Practice Interviews)

Questions for deliberation

1. Which of the identified strategies to optimise health service board meetings could be trialled and scaled across Victoria?

2. Of these, which is the highest priority for a pilot study and why?

3. What are appropriate success measures for a pilot study? [Consider 'lead' indicators (e.g. observable behaviours, attitudes, behavioural intention) as well as lag indicators (e.g. impact on health service operations, patient safety)]

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Appendix 1: Background and Context

VMIA Research and Innovation Program – Patient Safety in Victorian Public Healthcare

The research and innovation program is designed to create, synthesise and translate knowledge into patient safety policy and practice within the Victorian Public Health Sector. This program aims to foster research translation by reflecting on the Victorian Managed Insurance Authority's (VMIA) own policy and practice, partnering with the Department of Health and Human Services (DHHS) and building a broader community of interest around the program through academics, policy makers, clinicians and consumers. A secondary aim of the program is to position VMIA as a thought leader in patient safety and risk management.

About BehaviourWorks Australia

BehaviourWorks Australia (BWA) is an applied behaviour change research enterprise within Monash University's Sustainable Development Institute. BWA was established in 2011 and currently has ten consortium partners, including The Shannon Company, a social marketing firm who have delivered a range of large-scale government campaigns such as WorkSafe Victoria's 'homecomings' campaign and the 'Our Water Our Future' campaign launched during the major drought in Victoria in 2004. BWA's health research draws upon contemporary methods of knowledge translation (KT) designed to translate research evidence into practices, systems, and policies. We have applied this approach to various health projects covering adolescent and indigenous infant vaccination, the recently launched 'Help Save Lives By Saving 000 For Emergencies' campaign, and optimising practice for bladder care following acute spinal cord injury. For more information about BWA, refer to our website: http://www.behaviourworksaustralia.org/

How research projects are identified and prioritised

A series of structured activities to identify and prioritise topics are built into the research and innovation program. An initial 'rapid prioritisation' exercise was conducted in early 2017 which involved an in-depth review of VMIA activities; structured consultation with VMIA and the Victorian Department of Health and Human Services (DHHS); and the systematic development and application of criteria for prioritisation in collaboration with VMIA and DHHS. This resulted in the identification of the first three project areas including the present project (bold):

1. **Realising the potential of good governance in preventing harm, improving the patient experience and keeping per capita costs manageable**
2. Reducing under-, mis-, missed-, delayed- and over-diagnosis across sectors and conditions
3. Ensuring that healthcare choices, program and service design and organisational and system decision-making reflect the values and preferences of patients / caregivers / consumers

Following the rapid prioritisation, an expert panel with significant experience of health systems governance was convened to narrow the focus of the topic to an area that was *behavioural, testable in the short term (within 6 months)* and *scalable.* The resulting topic was ***Optimising health service board meeting processes and behaviours to better meet governance objectives.***

The final 3 project areas will be determined through a longer consultation exercise that draws in a wider group of stakeholders. This will involve surveying a Community of Interest representing all stakeholder groups relevant to the Research and Innovation Program to develop an exhaustive list of possible project areas within the scope of the program. Using the same prioritisation criteria developed in Activity 3, we will identify the highest three priorities for research projects. These will undergo the same development, implementation and evaluation process as the other three research projects.

Appendix 2: Methods

The Forum Approach

This project is using the Forum approach, an established method of promoting evidence- informed practice change, which involves four key activities:

1. Defining a major challenge through consultation with key stakeholders to understand the issues and complexities;
2. Gathering from published literature and further consultation the information necessary to properly consider the challenge, and presenting this in a briefing document (i.e. this document);
3. Convening a structured stakeholder dialogue to connect the information from the briefing document with the people representing key stakeholder groups who can make change happen; and
4. Reporting outcomes through a dialogue summary and related academic publications and briefing the organisations and individuals who can effect change about their role in developed strategies.

The Forum approach of evidence review and structured stakeholder dialogue was established by John Lavis in Canada in 2009. Subsequently Dr Peter Bragge and Professor Russell Gruen were funded by the Victoria n Transport Accident Commission from 2012 - 2015 to lead the first Australian-based Forum program, which focused o addressing high-priority challenges in brain and spinal cord injury care, research and policy. Outputs of the NTRI Forum program have been published online and in peer-reviewed literature. Satisfaction in the NTRI Forum process was high based up on participant surveys, with a mean score of 6.4 / 7 (where 1 is 'Failed' and 7 is 'Achieved') for ranking of how well the briefing document achieved its purpose (N =114, response rate 45%) and 6.0 / 7 for the stakeholder dialogue (N=192, RR 76%).

Literature Rapid Review

Search Strategy

A comprehensive search of the following databases was undertaken; Business Source Complete, Econolit, PsychINFO, PubMed and Google Scholar.

The PsychINFO search strategy is reproduced below:

Table 3: PsychINFO search strategy

	Search string	Results
1	((governance board or hospital board or health service board or board committee or board meeting or board member or board director or board chair) and (Oversight or self-assessment or culture or role of chair or collaboration or patient voice or team work or teamwork or behavior or behaviour or norms or time out or time-out)).	692
2	((governance board or hospital board or health service board or board committee or board meeting or board member or board director or board chair) and (Strategic objective or practical objective or patient safety or quality improvement or obligation or better meeting or objective or board maturity or effectiveness)).	434
3	((governance board or hospital board or health service board or board committee or board meeting or board member or board director or board chair) and (cognition or cognitive bias or perspective bias)).	112

Screening and selection

One reviewer screened the citations against the inclusion and exclusion criteria listed in Table 1. Data extracted from the included articles was used to inform a commentary on the implications of the review for governance practices for board meetings.

Table 4: Inclusion and Exclusion Criteria

	Included	Excluded
Study type	Systematic reviews and primary studies	
Study design	Observational or interventional	
Population	Corporate boards, health service boards, Board members, Board directors Board chairs, Sub-committees	
Intervention	Group interventions, behavioural interventions	Recruitment, board composition, diversity
Outcomes	Effectiveness, productivity, group processes, decision-making, team work	
Publication status	English language Peer-reviewed journal publication or public reports	

Practice Review Interviews

Interview Framework

The interviews were semi-structured, allowing the interviewers to explore emerging themes as well as salient issues (Spencer et al., 2003). The interview framework was as follows:

1. What does your role involve, what involvement do you have hospital boards?
2. Are there any general principles of good governance you see exemplified in practice at the hospital board level
3. In terms of improving governance at the board level and particularly thinking about board meetings, what has worked in practice
4. What hasn't worked as well as expected, or back-fired (e.g has there been resistance or difficulty in uptake)
5. What has been tried to running efficient and productive board meetings (to interrogate issues related to patient safety; asking better questions; understanding data/info)
6. How successful have these attempts been?
7. Are there any poor practices that should be removed/discouraged in board meetings

Participants

Participants were purposively selected based upon their experience and / or expertise in the area of governance in healthcare or healthcare boards (Patton, 1990).

Procedure

Participants were contacted via VMIA and invited to take part. Research aims and procedures were outlined in an explanatory statement given to all participants prior to the interview. All interviews were conducted via telephone and one was face-to-face. Interviews lasted between 25 and 45 minutes. All interviews were conducted by BW in August 2017. Interviews were digitally audio-recorded, transcribed verbatim, anonymised and stored securely.

Analysis

Interview transcripts were coded and analysed thematically (Boyatzis, 1998) using a computer-assisted qualitative data analysis software program (NVivo10, QSR International Pty Ltd 2014). Interview transcripts were coded according to emergent themes and any emerging topics relevant to the topic. Direct quotations from interview transcripts were used to illustrate key themes. The participant categories (I.e. role and responsibilities) have been de-identified.

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