Department of Health and Human Services

The Director’s Toolkit

Chapter 14: Understanding Data

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.\*

**\*Source**: Bismark, Marie M, Walter, Simon J and Studdert, David M, *The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria*, Australian Health Review, (2013), 37, p682–687. Available from the CSIRO here: <http://www.publish.csiro.au/ah/pdf/AH13125>

# Acronyms and definitions

The following acronyms and definitions were current at date of publication.

| Acronym | Full description |
| --- | --- |
| AACC | Aged Care Complaints Commissioner |
| AAQHC | Australasian Association for Quality in Health Care |
| AAS | Australian Accounting Standards and Interpretations |
| AASB | Australian Accounting Standards Board |
| ABF | Activity based funding |
| ACAS | Aged Care Assessment Services |
| AGM | Annual General Meeting |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AMA | Australian Medical Association |
| ASA | *Ambulance Services Act 1986* (Vic) |
| ASIC | Australian Securities and Investments Commission |
| AV | Ambulance Victoria |
| BBCAC | Building Board Capability Advisory Committee |
| BCV | Better Care Victoria |
| BMAC | Boards Ministerial Advisory Committee  |
| CBC | Council of Board Chairs |
| CEO | Chief Executive Officer |
| CFO | Chief Finance Officer |
| COO | Chief Operations Officer |
| DHHS | Department of Health and Human Services |
| DMS | Director of Medical Services |
| DPC | Department of Premier and Cabinet |
| DPI | Declaration of Private Interests |
| DRG | Diagnosis Related Groups |
| DSM-V | 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 to the ICD-10) for classification of mental disorders. |
| DTF | Department of Treasury and Finance |
| FMA | *Financial Management Act 1994* (Vic) |
| GiC | Governor in Council |
| HCC | Health Complaints Commissioner |
| HEER | Health Executive Employment and Remuneration Policy  |
| HMI | Hospital Mortality Indicator |
| HPV | Health Purchasing Victoria, trading as HealthShare Victoria |
| HSA | *Health Services Act 1988* (Vic) |
| HSMR | Hospital Standardised Mortality Ratios |
| IBAC | IndependentBroad-based and Anti-Corruption Commission |
| IHPA | Independent Hospital Pricing Authority |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems, 10th Revision. This is the disease classification used in Australia cf. DSM-VNotes: * 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
 |
| KPI | Key performance indicator |
| LHN | Local hospital network |
| LOS | Length of Stay |
| LTI | Lost Time Injury |
| MHA | *Mental Health Act 2014* (Vic) |
| MHCC | Mental Health Complaints Commissioner |
| MPS | Multi Purpose Service |
| NAESG | Non Admitted Emergency Services Grant |
| NDIS | National Disability Insurance Scheme |
| NEP | National Efficient Price (as determined by IHPA) |
| NSQHS Standards | National Safety and Quality Health Service Standards |
| NWAU | National Weighted Activity Unit against which NEP is paid (national equivalent of WIES) |
| OH&S | Occupational Health and Safety |
| OHSA | *Occupational Health and Safety Act 2004* (Vic) |
| OVA | Occupational Violence and Aggression |
| PAA | *Public Administration Act 2004* (Vic) |
| PDA | *Protected Disclosures Act 2012* (Vic) |
| PFG | Policy and Funding Guidelines (updated every year) |
| PMF | Performance Monitoring Framework |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | Public Sector Residential Aged Care Services |
| SCV | Safer Care Victoria |
| SoP | Statement of Priorities |
| SRHS | Small Rural Health Services |
| TRP | Total remuneration package (for an executive salary) |
| VAGO | Victorian Auditor General’s Office |
| VAHI | Victorian Agency for Health Information |
| VCC | Victorian Clinical Council |
| VGRMF | Victorian Government Risk Management Framework |
| VHA | Victorian Healthcare Association |
| VIFMH | Victorian Institute of Forensic Mental Health, also known as ‘Forensicare’ |
| VMIA | Victorian Managed Insurance Authority |
| VMO | Visiting Medical Officer |
| VPSC | Victorian Public Sector Commission |
| WIES | Weighted Inlier Equivalent Separation |

# Key definitions used in this Toolkit

|  |  |
| --- | --- |
| Definition | Full description |
| Consumers | ‘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. |
| Directors | 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. This includes members of the board of Health Purchasing Victoria, (trading as HealthShare).  |
| Enabling Acts[[1]](#footnote-1) | *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. |
| HLA Bill | 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. |
| HPV | 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. |
| Minister | In this Toolkit, Minister refers to the Victorian Ministers for Health, Ambulance Services, and Mental Health where applicable.  |
| Patient Experience Survey | 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. |
| People Matter Survey | 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. |
| Health services | 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.  |
| Secretary | The Secretary of the DHHS. |
| Victorian Clinical Council | 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. |

# Understanding data

## 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?[[2]](#footnote-2)
* 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)?

##

## 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.[[3]](#footnote-3)**

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 accurate and relevant to support and inform effective decision-making.

Getting assurance over information provided to the board involves relies on directors having two simple, but important skills – curiosity and healthy scepticism.



Figure ‑ Understanding data

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 $5million is not worth commentary. However, if that variance was $2million, 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.

|  |  |
| --- | --- |
| Externally available information | Within your own health service |
| Public inquiries (e.g. VAGO, reviews such as Targeting Zero)Networking events.Engagement with/information from agencies – SCV, DHHS, VAHI, VMIA.Newspapers and media.Peers and benchmarks. | Clinical reports.Staff surveys.Walk-arounds to observe culture, processes, the condition of assets etc.Patient experience questionnaires/stories.Board and committee reports and minutes.Internal audit report |

Table – 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.

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* World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)*, (2016). Available from the WHO here: <http://apps.who.int/classifications/icd10/browse/2016/en#/> \*Note: other languages available.

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. [↑](#footnote-ref-1)
2. Bismark, Marie M, Walter, Simon J and Studdert, David M, *The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria*, Australian Health Review, (2013), 37, p682–687. [↑](#footnote-ref-2)
3. 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. [↑](#footnote-ref-3)