

Governance of Local Health Districts

18 APRIL 2019



NEW SOUTH WALES AUDITOR-GENERAL'S REPORT

PERFORMANCE AUDIT

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In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled
'Governance of Local Health Districts'.

A handwritten signature in black ink, appearing to read 'Margaret Crawford'.

Margaret Crawford

Auditor-General
18 April 2019

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Section one

Governance of Local Health Districts



Executive summary

Fifteen Local Health Districts (LHDs) are responsible for providing public hospital and related health services in NSW. LHDs are:

- established as statutory corporations under the *Health Services Act 1997* to manage public hospitals and provide health services within defined geographical areas
- governed by boards of between six and 13 people appointed by the Minister for Health
- managed by a chief executive who is appointed by the board with the concurrence of the Secretary of NSW Health
- accountable for meeting commitments made in annual service agreements with the NSW Ministry of Health.

The NSW Ministry of Health (the Ministry) is the policy agency for the NSW public health system, providing regulatory functions, public health policy, as well as managing the health system, including monitoring the performance of hospitals and health services.

The current roles and responsibilities of LHDs and the Ministry, along with other agencies in NSW Health, were established in 2011 following a series of reforms to the structure and governance of the system. These reforms began with the report of the 'Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals' ('the Garling Inquiry'), which was released in 2008, and were followed by reforms announced by the incoming coalition government in 2011.

These reforms were intended to deliver greater local decision making, including better engagement with clinicians, consumers, local communities, and other stakeholders in the primary care (such as general practitioners) and non-government sectors.

The reforms empowered LHDs by devolving some management and accountability from the Ministry for the delivery of health services in their area. LHDs were made accountable for meeting annual obligations under service agreements.

This audit assessed the efficiency and effectiveness of the governance arrangements for LHDs. We answered two questions:

- Are there clear roles, responsibilities and relationships between the Ministry of Health and LHDs and within LHDs?
- Does the NSW Health Performance Framework establish and maintain accountability, oversight and strategic guidance for LHDs?



Conclusion

Main roles, responsibilities and relationships between LHDs, their boards, and the Ministry of Health are clear and understood, though there is opportunity to achieve further maturity in the system of governance for LHDs.

Main roles and responsibilities are clear and understood by local health district (LHD) board members and staff, Ministry of Health executive staff, and key stakeholders. However, there is some ambiguity for more complex and nuanced functions. A statement of principles to support decision making in a devolved system would help to ensuring that neither LHDs or the Ministry 'over-reach' into areas that are more appropriately the other's responsibility.

Better clinician engagement in LHD decision making was a key driver for devolution. This engagement has not met the expectations of devolution and requires attention as a priority.

Relationships between system participants are collaborative, though the opportunity should be taken to further embed this in the system structures and processes and complement existing interpersonal relationships and leadership styles.

Accountability and oversight mechanisms, including the Health Performance Framework and Service Agreements, have been effective in establishing accountability, oversight and strategic guidance for LHDs.

The Health Performance Framework and Service Agreements have underpinned a cultural shift toward greater accountability and oversight. However, as NSW Health is a large, complex and dynamic system, it is important that these accountability and oversight mechanisms continue to evolve to ensure that they are sufficiently robust to support good governance.

There are areas where accountability and oversight can be improved including:

- continued progress in moving toward patient experience, outcome, and quality and safety measures
- improving the Health Performance Framework document to ensure it is comprehensive, clear and specifies decision makers
- greater clarity in the nexus between underperformance and escalation decisions
- including governance-related performance measures
- more rigour in accountability for non-service activity functions, including consumer and community engagement
- ensuring that performance monitoring and intervention is consistent with the intent of devolution.



1. Key findings

Main roles and responsibilities of the LHDs and Ministry are clear and understood

The main roles of LHDs as the providers of public hospitals and related health services to local communities, and of the Ministry as system manager and purchaser are clear and well-understood.

There is good – and improving – collaboration between different parts of the system. This provides a sound foundation on which to further mature the governance arrangements for LHDs.

However, as can be expected in a large and inter-related system, there are areas of nuance and complexity where there is more likely to be ambiguity and uncertainty, including:

- the roles and relationships between the LHDs and the 'Pillar' agencies, particularly the Agency for Clinical Innovation and the Clinical Excellence Commission
- to what extent LHDs have discretion to pursue innovation
- individual responsibility and obligations between chairs, boards, executive staff, and the Ministry.

The quality and extent of clinician engagement in LHD decision making has not fulfilled the expectations of devolution

A key driver of the structural reforms to NSW Health in 2011 was to achieve strengthened clinical engagement in the health system, including in the planning and delivery of services.

This has not been achieved consistently.

Clinician engagement is, at best, variable across the health system. We found that the deep and broad engagement anticipated by the Garling Inquiry, by government policy and reform on devolution, by model by-laws for LHDs, and by NSW Health Governance Standards, has not been achieved with any consistency.

While it was beyond the scope of this performance audit to define the barriers to clinician engagement, identifying and overcoming them will require a collaborative effort between the Ministry, LHDs and clinicians.

There are no high-level rules or principles to help guide decision making where responsibilities are blurred or overlap

There is a good understanding of the main roles and responsibilities of LHDs and the Ministry. However, there are functions and activities that do not sit comfortably within existing formal responsibilities. One example is the implementation of innovation agendas across LHDs. Governance and oversight of this innovation is under-developed, which creates risks of duplication, inefficiency, program failure, lack of capability, and a lack of both transferability and interoperability.

There is confidence in NSW Health that legislation and delegation manuals can resolve any ambiguity that may arise in system participants' roles and responsibilities. Legislation and delegation manuals are foundational features of large systems and in a simple and stable system, this confidence could probably be justified. However, in a large, complex and dynamic system that is still evolving, this confidence is – by itself – insufficient.

It is likely that functions and activities already exist that do not sit comfortably within existing formal responsibilities. These functions and activities need to be better supplemented by principles.

These principles could assist in ensuring that neither LHDs or the Ministry 'over-reach' into areas that are more appropriately the responsibility of the other, such as with innovation initiatives. This would also help to ensure that extensive performance monitoring and intervention measures applied by the Ministry remain consistent with the policy intent of devolution.

The Health Performance Framework and Service Agreements are effective at managing expectations, but need to evolve to remain useful in practice

The Health Performance Framework and Service Agreement have played an essential role in driving a cultural shift in the system. There is now an understanding among LHDs, the Ministry, and consumers that LHDs should be transparent about what they do and how well they do it.

The importance of driving this cultural shift should not be underestimated.

There is now opportunity for these accountability and oversight mechanisms to evolve to match and support greater maturity in LHD governance arrangements. The current progress toward better performance measures is important and welcomed.

Areas where more work is needed include:

- a framework that better reflects all the performance monitoring and reporting that is done, including to ensure that it is comprehensive and cohesive
- more robust ways of ensuring that LHDs are accountable for non-service activity functions, like community and stakeholder engagement
- more clarity around how the escalation process works and how escalation decisions are made
- a clear pathway for how good practice can be shared between LHDs
- greater assurance that performance monitoring and intervention is consistent with the intent of devolution to afford LHDs greater responsibility for the delivery of health services in their area.



2. Recommendations

1. By December 2019, the Ministry of Health should:
 - a) work with LHDs to identify and overcome the barriers that are limiting the appropriate engagement of clinicians in decision making in LHDs
 - b) develop a statement of principles to guide decision making in a devolved system
 - c) provide clarity on the relationship of the Agency for Clinical Innovation and the Clinical Excellence Commission to the roles and responsibilities of LHDs.
2. By June 2020, LHD boards, supported where appropriate by the Ministry of Health, should address the findings of this performance audit to ensure that local practices and processes support good governance, including:
 - a) providing timely and consistent induction; training; and reviews of boards, members and charters
 - b) ensuring that each board's governance and oversight of service agreements is consistent with their legislative functions
 - c) improving the use of performance information to support decision making by boards and executive managers.
3. By June 2020, the Ministry of Health should improve accountability and oversight mechanisms by:
 - a) revising the Health Performance Framework to ensure it is cohesive, clear and comprehensive
 - b) clarifying processes and decision making for managing performance concerns
 - c) developing a mechanism to adequately hold LHDs accountable for non-service activity functions
 - d) reconciling performance monitoring and intervention with the policy intent of devolution.



1. Introduction

1.1 Background

Local Health Districts

The provision of public hospital and related health services in NSW is primarily done by 15 LHDs.¹ LHDs are established as statutory corporations under the *Health Services Act 1997* and manage public hospitals and provide health services within defined geographical areas. The primary purposes of LHDs are to:

- provide relief to sick and injured persons through the provision of care and treatment
- promote, protect and maintain the health of the community.

The functions of the LHDs are set out in Appendix two.

LHDs are governed by boards appointed by the Minister for Health. By law, these boards are required to include between six and 13 members who provide an appropriate mix of skills and experience, which must include:

- expertise and experience in matters such as health, financial or business management
- expertise and experience in the provision of clinical and other health services
- where appropriate, are representatives of universities, clinical schools or research centres
- knowledge and understanding of the community
- other background, skills, expertise, knowledge or experience appropriate for the organisation
- understanding of or experience in primary care
- expertise, knowledge or experience in relation to Aboriginal health.

The functions of LHD boards are shown in Appendix three.

LHDs are managed by an executive team, all of whom except the chief executive are appointed by the Secretary of NSW Health (the Health Secretary). Chief executives are appointed by the respective LHD board with the concurrence of the Health Secretary.

1.2 Reform to governance in NSW Health

Devolution of management and accountability

The current governance arrangements for LHDs were established in 2011.

Under its 'Plan to Provide Timely, Quality Health Care', the Liberal National Government was elected in March 2011 with a policy to devolve the management and governance of the NSW's public healthcare services to LHDs governed by boards.

On 1 July 2011, legislation to establish 15 LHDs and their boards came into force, supported by governance arrangements to devolve responsibility and accountability within the health care system and improve the capacity of health services to respond to the needs of the communities they serve.

The reforms were underpinned by a desire to make public health services more responsive to local needs, including through engagement with the local community, a greater decision-making role for local clinicians, and local boards that had visibility and local knowledge to provide strategic direction. Local health service provision is guided by system-wide strategy, policy, and oversight.

¹ There are also two Speciality Health Networks: the Sydney Children's Hospitals Network (including the Sydney Children's Hospital, Randwick, the Children's Hospital at Westmead, and related services and facilities) and the Justice Health and Forensic Health Network, which delivers health care to adults and young people in contact with the forensic mental health and criminal justice systems.

This policy pre-dated, but was consistent with, the Council of Australian Governments national health reform agenda, under which all state and territories agreed to devolve management and accountability of public hospital and health services to local authorities.

These reforms built upon existing changes in NSW Health that had resulted from the 2008 'Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals' (the 'Garling Inquiry'), which included the creation of the four 'Pillar' agencies of the hospital system:

- Agency for Clinical Innovation (ACI)
- Clinical Excellence Commission (CEC)
- Bureau of Health Information (BHI) and
- Health Education and Training Institute (HETI).

Report into NSW governance arrangements for LHDs

In August 2011, the then NSW Minister for Health, the Hon. Jillian Skinner, released a report that sought to further progress this reform agenda.² This report outlined:

...new governance arrangements aimed at ensuring NSW Health is a strong and resilient health system able to deliver the excellent health outcomes we expect for our patients and the broader community.

This report envisaged roles and responsibilities of various stakeholders within NSW Health and established a (much smaller) Ministry of Health as a system manager and purchaser of health services from LHDs, and with Westminster-system responsibilities for supporting the Minister and government. The Ministry's functions relate to regulation, public health, and management of the health system, including monitoring the performance of hospitals and health services.

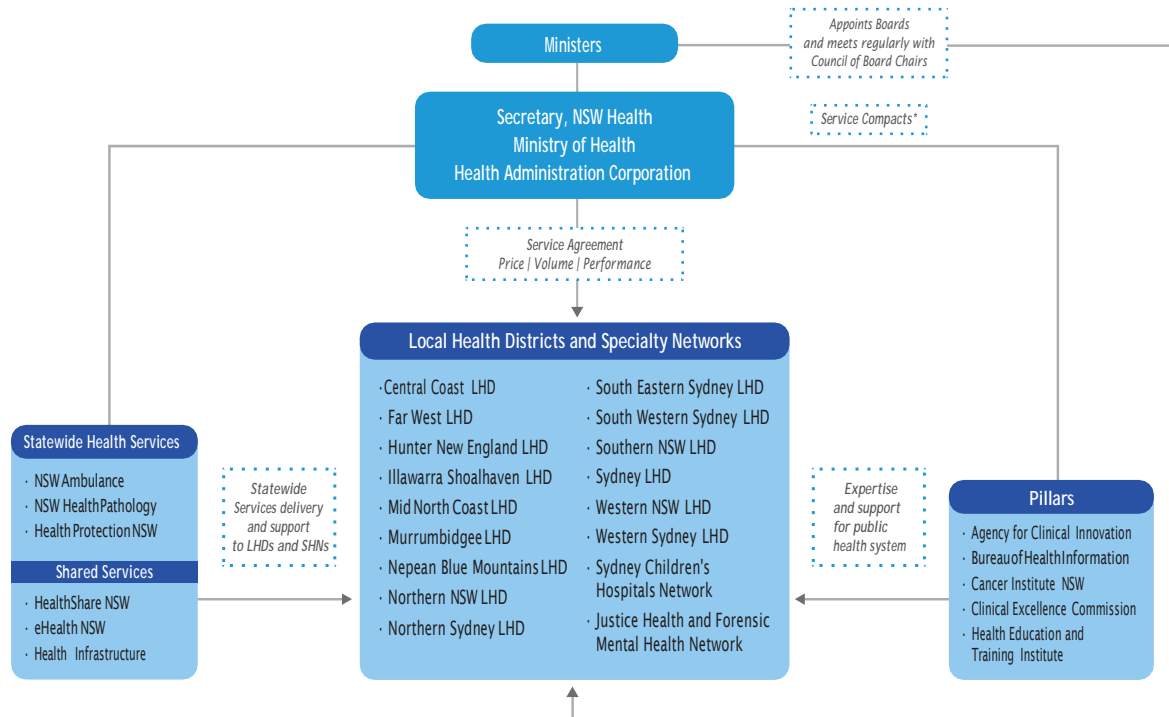
These reforms were intended to demonstrate the NSW Government's:

...strong commitment to devolve decision making to the local level and to actively involve clinicians, Medicare Locals, aged care and other care providers, patients and the community in public health services.

² NSW Health (2011) 'Future Arrangements for the Governance of NSW Health - Report of the Director General', available at <https://www.health.nsw.gov.au/healthreform/Documents/governance-report.pdf>.

Exhibit 1 below shows the current structure of the NSW Health system.

Exhibit 1: Structure of NSW Health



St Vincent's Health Network is an affiliated health organisation.

*Service Compact — Instrument of engagement detailing service responsibilities and accountabilities.

Source: NSW Health <https://www.health.nsw.gov.au/about/nswhealth/Documents/nsw-health-org-chart.pdf>.

1.3 Health system governance

Defining governance

There are many definitions of governance that use different concepts such as 'leadership', 'stewardship', 'control', 'regulation' and 'oversight'.³

The NSW Treasury describes governance as providing '...the direction and structure required to meet organisational objectives and enables your agency to properly manage its operations'.

The same agency draws on a superseded 2003 definition of governance provided by the Australian National Audit Office (ANAO) as '...the set of responsibilities and practices, policies and procedures, exercised by an agency's executive, to provide strategic direction, ensure objectives are achieved, manage risks and use resources responsibly with accountability'.

³ See, for example, Barbazza E and Tello, J (2014), 'A review of health governance: Definitions, dimensions and tools to govern' Health Policy 116, pp.1–11.

The ANAO's most recent description of public sector governance was provided in its 2014 better practice guide 'Public Sector Governance: Strengthening performance through good governance'. In this guide, which has now been withdrawn,⁴ public sector governance was described as:

...the arrangements and practices which enable a public-sector entity to set its direction and manage its operations to achieve expected outcomes and discharge its accountability obligations.

Public sector governance encompasses leadership, direction, control and accountability, and assists an entity to achieve its outcomes in such a way as to enhance confidence in the entity, its decisions and its actions.

The NSW Audit Office has described good governance in similar terms, particularly the focus on ensuring accountability, transparency, and compliance.⁵

Health system governance

The definition of health system governance builds upon, and is broadly consistent with, these general definitions and descriptions. The World Health Organisation (WHO) describes health system governance as referring to:

...a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage.

The WHO views health system governance as a political process that involves balancing competing influences and demands. It includes:

- maintaining the strategic direction of policy development and implementation
- detecting and correcting undesirable trends and distortions
- regulating the behaviour of a wide range of actors – from health care financiers to health care providers
- establishing transparent and effective accountability mechanisms
- collaborating with other sectors, including the private sector and non-governmental organisations.

In the health context, good governance includes greater emphasis on engaging with and protecting stakeholder rights by including them in decisions that affect them.⁶

⁴ As at August 2018, the ANAO has withdrawn all better practice guides.

⁵ NSW Audit Office (2017), 'Governance Lighthouse – Strategic Early Warning System', <https://www.audit.nsw.gov.au/about-us/governance-framework/governance-lighthouse>.

⁶ Barbazza and Tello (2014), 'A review of health governance: Definitions, dimensions and tools to govern' Health Policy 116, pp.1–11.

Governance in health systems operates on multiple levels.⁷ In NSW, these levels can be conceived as:⁸

- **system-level governance**, with the Ministry of Health exercising policy and governance functions over the system as whole system (including through funding and monitoring) and where the focus of decision making is strategic and system-wide
- **LHD-level governance**, where boards and executive management are responsible for governance over their local services, including in managing health service delivery and in how these services engage with the rest of the system
- **institution-level governance at the hospital or service level**, where the focus is to align governance with operational decisions.

These levels can be blurred, as policy, management and institutional governance are often intertwined,⁹ especially under Westminster-systems of government.

This audit focused on the governance arrangements for LHDs at the two top levels, particularly the extent to which they are cohesive and complementary.

Exhibit 2 below outlines the key sources of governance for NSW LHDs that have been considered in this audit.

Exhibit 2: Key sources of governance for NSW Local Health Districts

For the purposes of this audit, the key governance instruments are:

- *Health Services Act 1997* – which specifies a range of functions, powers and accountabilities for various parties in NSW Health, including a broad authority for the Secretary to '...provide governance, oversight and control of the public health system and the statutory health organisations within it'. Notably, LHD boards are appointed by the Minister, with LHD boards in turn appointing LHD chief executives.
- Charters and Terms of Reference of boards and board sub-committee.
- NSW Health Performance Framework – sets out performance expectations for LHDs to achieve the required levels of health improvement, service delivery and financial performance – this model also supports an 'earned autonomy' approach to system control, whereby LHDs with good performance records are less likely to be actively monitored by the Ministry than LHDs with poorer records.
- Service agreements – negotiated annually between the Ministry (as purchaser) and each LHD (as service providers) these instruments are a 'central component of the Performance Framework' and set annual standards for service and performance (for LHDs), as well as funding (from the Ministry).
- Corporate Governance and Accountability Compendium – sets out seven governance standards for LHDs and requires annual attestation statements be published outlining LHDs' governance arrangements and key information relating to their operation.
- Policy directives and model by-laws – policy directives issued by the Ministry are binding, while LHD model by-laws are made by the Secretary and may only be amended by individual LHDs with the approval of the Secretary.

'Tuning Governance and Accountability' project

Since May 2018, the NSW Ministry of Health has been conducting a project named 'Tuning Governance and Accountability' (the 'Tuning Governance' project).

This project was established to identify and address aspects of governance where, it was felt, existing approaches could be improved or where greater clarity of roles, responsibilities and relationships could be achieved. Two working groups have been established to guide progress and planning of the project.

⁷ Saltman R and Duran A (2015) 'Governance, Government, and the Search for New Provider Models' International Journal of Health Policy Management 5(10), pp.33–42.

⁸ There is also a national level, including the policy and funding roles of the Australian Government, as well as the functions of the COAG Health Council, though this is outside of the scope of this audit.

⁹ Sumaha A, Baatiemac L, and Abimbolad S (2016) 'The impacts of decentralisation on health-related equity: A systematic review of the evidence' Health Policy, 120, pp.1183–1192.

The Ministry briefed the Audit Office on the 'Tuning Governance' project as part of the scoping phase for this audit. Subsequently, the Audit Team interviewed Ministry staff in further detail about this project as part of the conduct phase of this audit.

The 'Tuning Governance' project is expected to be a continuing piece of work, progressively working through specific targeted priorities. This audit was conducted in parallel with the initial stages of the project.

The findings and recommendations of this audit may complement the project and the deliberations of the working group members. However, the analysis, findings and recommendation presented in this report have been prepared independently from the 'Tuning Governance' project.

1.4 About this audit

This audit assessed the efficiency and effectiveness of the governance arrangements for LHDs. We answered two audits questions:

- Are there clear roles, responsibility and relationships between the Ministry of Health and LHDs and within LHDs?
- Does the NSW Health Performance Framework establish and maintain accountability, oversight and strategic guidance for LHDs?

To do this, the audit reviewed governance arrangements in five selected LHDs that provided an appropriate mix of size and location. These LHDs were:

- Hunter New England
- Murrumbidgee
- Southern NSW
- South Eastern Sydney
- South Western Sydney.

The audit also examined the role of the NSW Ministry of Health (the Ministry) in establishing and maintaining LHD governance arrangements.

As part of the audit, we:

- interviewed senior management in each of the five LHDs
- interviewed chairs of the boards of each of the five LHDs
- interviewed chairs of selected board committees in the five LHDs
- interviewed senior management in three of the NSW Health 'Pillar' agencies, namely the Agency for Clinical Innovation, the Clinical Excellence Commission and the Bureau of Health Information
- interviewed expert external stakeholders
- reviewed documentation relating to governance in the five LHDs and the Ministry, including:
 - governance-related frameworks, policies, legislation and by-laws
 - board and committee charters
 - board and committee papers and minutes
 - LHD performance reports and planning documents
- conducted a survey of the members of all LHD boards in NSW, with a total of 129 responses.



2. Roles, responsibilities, and relationships



There is clear understanding of the main roles and responsibilities of LHDs and the Ministry of Health under the structural and governance reforms introduced in 2011. Strongly collaborative relationships provide a good foundation on which governance arrangements can continue to mature, though there is a need to better ensure that clinicians are involved in LHD decision making.

NSW Health is large and complex system, operating in a dynamic environment. The governance reforms introduced in 2011 were significant and it is reasonable that they take time to mature.

The main roles of LHDs and the Ministry are clear and well-understood, and there is good collaboration between different parts of the system. This provides a sound foundation on which to further mature the governance arrangements of LHDs.

While the broad roles of LHDs, their boards, and the Ministry are well understood by stakeholders in the system, there are matters of detail and complexity that create ambiguity and uncertainty, including:

- the roles and relationships between the LHDs and the Pillars
- to what extent LHDs have discretion to pursue innovation
- individual responsibility and obligations between chairs, boards, executive staff, and the Ministry.

These should be addressed collaboratively between boards, their executives, and the Ministry, and should be informed by a statement of principles that guides how devolved decision making should be implemented.

Better clinician engagement in health service decision making was a key policy driver for devolution. Priority should be given by LHDs and the Ministry to ensuring that clinicians are adequately engaged in LHD decision making. It appears that in many cases they are not, and this needs to be addressed.

The quality of board decision making depends on the information they are provided and their capacity to absorb and analyse that information. More can be done to promote good decision making by improving the papers that go to boards, and by ensuring that board members are well positioned to absorb the information provided. This includes ensuring that the right type and volume of information are provided to boards, and that members and executive managers have adequate data literacy skills to understand the information.

Recommendations

1. By December 2019, the Ministry of Health should:
 - a) work with LHDs to identify and overcome barriers that are limiting the appropriate engagement of clinicians in decision making in LHDs
 - b) develop a statement of principles to guide decision making in a devolved system
 - c) provide clarity on the relationship of the Agency for Clinical Innovation and the Clinical Excellence Commission to the roles and responsibilities of LHDs.
2. By June 2020, LHDs boards, supported where appropriate by the Ministry of Health, should address the findings of this performance audit to ensure that local practices and processes support good governance, including:
 - a) providing timely and consistent induction; training; and reviews of boards, members and charters
 - b) ensuring that each board's governance and oversight of service agreements is consistent with their legislative functions
 - c) improving the use of performance information to support decision making by boards and executive managers.

2.1 Understanding and fulfilling roles and responsibilities

Roles and responsibilities of the LHDs and Ministry are generally well understood

Among stakeholders in the system, and particularly decision-makers in LHDs and the Ministry, there is clear understanding of the main roles of LHDs and the Ministry of the Health. The broad functions of LHDs as the providers of public hospitals and related health services to local communities, as well as the dual roles of the Ministry as system manager and purchaser, are understood.

This understanding was particularly evident when discussing service agreements made annually between LHDs and the Ministry. As discussed in Section 3 of this report, there is a shared understanding that the roles of these are to express the Ministry's high-level expectations and strategies for health service delivery by LHDs, as well as functioning as, effectively, purchase orders under the purchaser-provider model.

However, as can be expected in a large, complex and evolving system, there are areas of nuance and ambiguity.

Better understanding in LHDs of the roles and responsibilities of Pillar agencies

At all levels across LHDs, there was uncertainty expressed about the roles and responsibilities of the Pillar agencies. This was particularly the case for the Agency for Clinical Innovation (ACI) and the Clinical Excellence Commission (CEC).

The ACI and CEC play an important role in how health services are delivered by LHDs. While some initiatives from these agencies are designed to offer guidance or good practice, others are mandatory and become obligations included in service agreements – most prominent of these currently is the Leading Better Value Care program. This program mandates models of care and ways of delivering services for all LHDs for priorities determined at the system-level.¹⁰

Our survey of board members found that around 20 per cent did not have a clear understanding of the roles and responsibilities of the Pillar agencies. This uncertainty was also found in internal board assessments conducted in some LHDs, as well as interviews with LHD executive staff.

There were a number of themes raised by LHDs regarding relationships to the Pillars, including that the latter:

- may introduce unnecessarily complication, particularly through overlap and duplication
- may be intrusive, including where LHDs have effective existing models of care
- may be excessively prescriptive, including to propose models of care that are unsuitable to local circumstances (particularly in rural and regional areas)
- lack clarity in how they determine priorities for their initiatives, which can result in lack of alignment to LHD priorities
- may not be sufficiently responsive to the needs of LHDs.

It is important to stress that the Pillars are not the subject of this audit, and we have not explored the validity of these views. Further, while there is an imperfect understanding of the roles and responsibilities of the Pillars, there was a broad consensus across LHDs that the Pillar agencies are increasingly important and useful resources for LHDs.

Ensuring that the roles and responsibilities of the Pillar agencies – especially the ACI and CEC – are better understood by LHDs will contribute to the maturing of governance arrangements and relationships. It will also ensure that LHDs are able to maximise the value of the Pillars to improving how they deliver health services.

¹⁰ There are eight initiatives in the first tranche of priorities in the Leading Better Value Care program. These relate to: osteoarthritis, osteoporosis re-fracture prevention, chronic obstructive pulmonary disease, chronic heart failure, diabetes, diabetes high risk foot services, falls in hospitals, and renal supportive care.

Relatedly, there was also confusion among some LHD staff on the role of the Ministry's Patient Safety First Unit, particularly as it relates to the quality and safety remit of the CEC. While there was a loose understanding that the two parties served, respectively, 'black hat' (regulatory) and 'white hat' (good practice and support) functions, the imperfect understanding among people in senior and highly relevant positions in LHDs was notable.

Board members report a clear understanding of their roles and responsibilities

The role of LHD boards is to provide high-level oversight and governance of their services. They are not tasked with making routine operational decisions. The expression 'noses in, fingers out'¹¹ was used in LHDs and the Ministry to describe an understanding of the boards' role in operational matters. This expression was also referenced in NSW Health training resources for statutory boards.

Our survey of board members found that they were confident in their understanding of their individual role, as well as the functions of the board collectively. This was supported by internal board assessments conducted in some LHDs.

There was a broad consensus among interviewed LHD executives that boards have the right focus on strategic and governance matters, and there were few examples given where boards had been seen to stray into 'operational matters'.

It is noteworthy, though, that there was lack of clarity around what constituted 'operational'. For example, there were occasions where:

- board members felt that management was uncooperative about matters that management felt were operational, but members felt were strategic
- boards pushed back against dealing with matters that were ordinarily operational, but which had not been adequately dealt with by management (such as in the case of staff complaints).

Training and induction should include advice on how to deal with scenarios where the distinction between operational, strategic and governance matters may be nuanced or complex.

Boards are performing their key functions, but could be more engaged in setting direction for service agreements

The Audit found that boards are routinely and actively engaged in key functions, such as:

- contributing to strategic planning for their LHDs
- reviewing progress against key financial and clinical performance measures
- in some cases, overseeing and monitoring projects and programs that derive from strategic and operational plans
- ensuring clinical governance frameworks were established and implemented
- increasingly, in monitoring and fostering a culture that promotes patient quality and safety – the inclusion of real-life, detailed 'patient stories' in many board meetings exemplifies this focus.

However, we were unable to determine a clear role for boards in the annual process of negotiating service agreements between LHDs and the Ministry of Health. This is significant given the importance of service agreements in determining funding and activity, as well as influencing LHDs operational focus. Our survey of board members found that 94 per cent of respondents reported that service agreements were important or very important to their board's decision making about important matters.

Board minutes reveal that service agreement negotiations were regular agenda items (though not necessarily for every meeting during the negotiation period). In most cases, these items were board briefings for noting, rather than for a decision. There were few examples where board minutes suggest active discussion and consideration of issues emerging during the process.

¹¹ Sometimes known by its acronym 'NIFO', this refers to a strategy or approach to board behaviour where the focus is placed on board members retaining active oversight of governance, strategy and high-level performance ('noses in'), without intruding into day-to-day management ('fingers out').

Our interviews with senior executives and office-holders in LHDs, including chairs and chief executives, revealed that, in most cases, boards do not play an active role in service agreement negotiations. One board member commented that:

[The] Service Agreement appears to be a document that is considered by Executive Team and negotiated with Ministry staff and then presented to Board literally days before it is due to be returned to the Ministry. If that is the process experienced across the state, then are we decision making Boards or rubber stampers?

Concern was also expressed among some senior executives and board members in LHDs that service agreements are essentially the product of a 'one-way process between parties of unequal power', which 'circumvent the board's ability to govern'. It is accurate that, in the event that a negotiated agreement cannot be reached, a service agreement may be imposed on an LHD by the Ministry.

Relevantly, the statutory functions of boards include not only to provide final approval of service agreements, but to:

...confer with the chief executive of the local health district in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement (*Health Service Act 1997* s.28(1)(f)).

Given the importance of these agreements, boards should, from time to time, actively review whether they remain comfortable with the nature and extent of their engagement in this process.

Relationships between positions carry risks of conflicted interests or obligations

While many interviewees described a sound level of understanding of roles and responsibilities between LHDs and the Ministry, there are areas more likely to be ambiguous and uncertain.

There are three types of relationships that may warrant further consideration, including as part of the 'Tuning Governance' project.

First, whether the relationship and accountabilities between executives and board members are clear.

Boards exercise employer functions in regard to the chief executive, though the Secretary of Health exercises employer functions for all other senior executives in LHDs. Some board members said that this leads to senior executives being insufficiently transparent, collaborative and responsive to the Board. Further practical guidance could be provided in induction and training explaining the board's sources of authority in LHDs, as well as to what extent executives are accountable to the board.

Second, whether the chief executives' accountabilities are sufficiently clear in practice.

LHD chief executives may only be appointed or dismissed by the board with the concurrence of the Health Secretary. Chief executives have the authority to manage and control the affairs of the LHDs and are, in the exercise of his or her functions, accountable to the Local Health District Board.

In addition, the Health Secretary has a reserve power to terminate a chief executive themselves. In effect, it was suggested, this creates a situation where chief executives have 'two masters', potentially confusing responsibility and accountability.

To ensure that there is clarity in chief executives' accountability to their boards, LHDs should ensure clear protocols are in place for how chief executives keep their boards informed of interactions with the Health Secretary and the Ministry, particularly on matters that are more than simply operational.

Third, whether there is enough guidance to chairs about balancing their working relationship with the chief executive and their role in leading the board.

We found there were instances where staff and boards members had formed the view that chairs had focused on establishing and maintaining their relationship with the chief executive to the detriment (or perceived detriment) of their responsibilities to fellow board members: by way of example, in one instance, the relationship was described as 'too cosy'.

It is important that chairs maintain open and collaborative working relationships with their chief executive, while at the same time meeting their obligations to be 'responsible for leading the board, facilitating the effective contribution of all directors and promoting constructive and respectful relations between directors and between the board and management'.¹²

Maintaining board quality through induction, training and review

Adequate induction, ongoing training and development, and regular collective and individual performance reviews are important tools to ensuring that boards retain the high level of skills and knowledge required to provide oversight of complex organisations.

Despite being standard requirements of board charters, our survey of board members found that:

- 33 per cent did not get adequate induction and training
- 28 per cent did not have annual reviews of the board's performance
- 40 per cent did not have their own performance reviewed.

Several boards have committed to ensure that their members undertake relevant training provided by the Australian Institute of Company Directors (AICD). In addition, training and induction materials are facilitated or provided to new board members by the Ministry of Health.

At Hunter New England LHD, in addition to annual performance reviews, feedback is collected after each board meeting to drive innovation and improvement in board processes. Any issues of concern are discussed at subsequent board meetings. This includes obtaining feedback from meeting participants on issues such as:

- appropriateness of meeting logistics
- meeting efficiency and effectiveness
- progress on key strategic issues
- relationship between board and chief executive.

Overall, the Audit found that there is a need to improve commitment of boards and LHDs to ensuring high-quality and timely induction, training, and review of boards, their members and charters.

Board and executive development planning should assess the need for data literacy

It is important for board and committee members, as well as executive level staff who provide briefings, to have effective skills at reviewing and analysing data. The audit found an essential need, which was not always met, for decision makers to be well skilled in understanding health, financial, and operational performance data. Strong skills in these areas are important due to the substantial volume of performance information presented to boards and committees, its diversity in underlying subject matter, its inherent complexity, and its importance to measuring and tracking performance.

This could include accessing resources such as the training provided by the Clinical Excellence Commission on interpreting quality and safety performance measures, or the capability building offered by the NSW Health Centre for Epidemiology and Evidence.

Hunter New England LHD has instituted its own effective method for developing data literacy skills. In that LHD, board members conduct 'deep dives' into Key Performance Indicators of interest, meeting with subject matter experts on the underlying subject matter, and actively reporting back to the board on their learnings.

¹² ASX (2014) 'Corporate Governance Principles and Recommendation' available at <https://www.asx.com.au/documents/asx-compliance/cgc-principles-and-recommendations-3rd-edn.pdf>.

The quality of board and committee papers can be improved, to help focus discussion and decisions on the important things

The quality of board papers is important to the functioning of boards. These papers can be improved, particularly the presentation of performance information, which can be dense, technical and voluminous. This view was summed up by one board member: 'Board papers are complex and numerous and too little information and too much information can lead to poorly informed decision making. Getting the information balance right is critical but challenging'.

In some cases, there is evidence that LHDs have already been, or are being, responsive to board and board sub-committee requests for better presentation of performance information. For example, South Eastern Sydney LHD has developed an internal 'Integrated performance report' which provides a simple and effective template. This template displays for each performance measure the 'performance' (the result achieved), 'impact' (what the result means), and 'action' (what will be done).

Minutes should aid the understanding, recall and review of decisions

There is a substantial variation in the amount of detail recorded in board and committee minutes. Some minutes provide good detail that ensures a clear understanding of how an agenda item progressed to a decision. However, other minutes provided no commentary and only record attendance, agenda items, and where a decision was made or a matter noted.

Some minutes noted verbal updates from senior office holders, with little or no explanation of what was even included in the verbal update. The practice of unminuted verbal updates from senior officers is not good practice and does not promote transparency and accountability.

While board minutes are not intended as transcripts, good practice guidance increasingly supports the inclusion of broad reasons for decisions, as well as a brief outline of factors material to the decision.

Further consideration is required about the most appropriate way to record and publish the minutes of board and committee meetings. This should include whether a Ministry policy directive is appropriate (noting that a previous policy directive on publishing board minutes was rescinded in 2014).

The NSW Health Corporate Governance and Accountability Compendium is a good document, but needs updating

The Governance and Accountability Compendium is a detailed and useful document. We found that it is well-regarded by people who routinely had reason to use it. One Chair described it as the 'Bible' that provides guidance to the functioning of the board.

The current version is dated May 2013 and is past its review date of 1 July 2017. A review of the compendium should include issues raised in this audit, especially areas where we have identified a need for further guidance or advice.

2.2 Effectiveness of relationships

There is improved collaboration between LHDs and the Ministry

Relationships between LHDs and other parts of NSW Health – particularly the Ministry – have become increasingly collaborative in recent years.

This collaboration is consistent with NSW Health values (CORE: 'collaboration', 'openness', 'respect', and 'empowerment'). Individuals in LHDs particularly highlighted the value of senior ministry executives conducting site visits to LHDs, something which has not been historical practice.

This greater collaboration and improved communication were frequently attributed to the individual leadership styles and interpersonal skills of a small group of senior executives who effectively modelled positive behaviours in their interactions with LHDs.

At the same time, relying on the personal styles and goodwill of current organisational leaders has the potential to create key person risk. The current collaborative environment is built on interpersonal relationships, and less on structures. This may risk the long-term sustainability of these behaviours and practices.

Accordingly, while the personal style of senior executives plays an essential role in fostering collaboration and communication, there is an opportunity for NSW Health to better institutionalise collaborative behaviours by embedding good practices, structures and processes.

This could include at every level, from individuals (such as the content and outcomes of individual performance management), through to organisational structures (such as formalising and reinforcing new and emerging collaborative forums).

There can be better governance of existing networks and forums

There are clinical and managerial networks within NSW Health at varying degrees of formality and organised from different points within NSW Health.

At the highest level, there is the Senior Executive Forum (SEF) and the Council of Board Chairs, each of which exists in part to offer opportunities for chief executives and chairs to share ideas and problems. These two are organised by the Ministry but allow significant input from chief executives. There are also formal Tier 2 Director meetings across NSW Health, as well as many primarily clinically-themed networks led by the Agency for Clinical Innovation.

There are also many communities of practice and other networks at various levels across LHDs and agencies. These can emerge in an ad hoc or organic way.

The audit did not find any overall schematic to describe how these various forums interact, nor any evidence that they do. While these forums should be encouraged, there is also value in ensuring that they are subject to adequate governance to ensure that they are appropriately constituted and serve a clear purpose. These measures will help to ensure that they remain relevant, accessible, efficient and effective, including by avoiding duplication and overlap, and by exploiting any synergies.

For example, a register of forums and networks could be maintained, much as the ACI maintains a publicly available list of its clinical networks, taskforces and institutes. This could be supported by simple governance resources, such as advice on forming terms of reference and simple guidance on how to maintain a network or forum. The Ministry has already done an effective job in organising its own System Governance Committees into a coherent framework, supported by terms of reference, supporting guidelines for the conduct of committees, as well as process and administrative templates for committees.

Relationships between LHDs are maturing from competitive to collaborative

Despite being part of a state-wide public health system, LHDs have traditionally functioned somewhat more competitively than collaboratively. This resulted in what some stakeholders described as a system that functioned as a collection of 'fiefdoms'.

The audit found that as collaboration between LHDs and the Ministry has improved, so too has collaboration improved between the 15 LHDs. This was evidenced by such initiatives as:

- South Western Sydney LHD has entered a strategic partnership with its neighbouring Western Sydney LHD and the two have held joint board meetings.
- South Eastern Sydney LHD has driven the establishment of an LHD Innovation Network that aims to develop working relationships between LHDs, NSW Health Pillars and Speciality Health Networks to provide support and guidance to peers in the implementation of innovation.
- The chief executives of the eight rural LHDs participate in a collaborative monthly meeting to discuss common issues relating to service provision outside metropolitan areas.
- Hunter New England LHD has explored options to ensure that coronial findings and recommendations are shared across all LHDs.

These initiatives reflect the maturing of LHDs by lessening their reliance on the Ministry, while encouraging a shared approach to solving common problems. These examples are in addition to the many regular or semi-regular forums run for Tier 2 Directors and clinical stream leaders across LHDs.

However, there is still room for improvement. LHDs can still be competitive, rather than collaborative.

For example, we noted resistance to the idea of LHDs sharing risk registers and mitigation strategies. The source of this hesitation was a concern that LHDs might not be willing to 'share their dirty laundry' or their source of competitive advantage or disadvantage with their 'competition' in other LHDs.

The Audit was also told of examples where health service planning staff in some LHDs had refused to share service plans with other LHDs. The need for more coordinated and system-focused planning has been raised in other performance audits.¹³

The current level of clinician engagement is deficient and is not meeting the intent of devolution

There is a need to improve how well clinicians are engaged in decision making in LHDs.

The Garling Inquiry of 2008 highlighted the importance of clinician engagement in the health system. The final report of that inquiry highlighted the need to '...engage the dedication of clinicians in designing new models of care which are supported and actively championed by clinical leaders in the field'.

This was reinforced by the incoming NSW Government in 2011. The suite of NSW Government policy statements that accompanied structural reform (devolution) included that there should be 'strengthened clinical engagement' in the health system, including in the '...planning and delivery of efficient, world-class health services'. This policy was intended to ensure 'Clinician engagement in the design of models of care and decision making for local and system-wide policies to ensure quality, safety and effectiveness of care.' This is reinforced in the annual service agreements between LHDs and the Ministry, which note that:

Consistent with the principles of accountability and stakeholder consultation, the engagement of clinical staff in key decisions, such as resource allocation and service planning, is crucial to the achievement of local priorities.

Further, Part 5 of the NSW Health model by-laws require that LHDs must:

...establish the following structures and forums to provide input for medical, nursing and allied health staff:

- (a) Medical Staff Councils and Medical Staff Executive Councils...
- (b) Hospital Clinical Councils and Joint Hospital Clinical Councils...
- (c) A Local Health District or Specialty Health Network Clinical Council.

The inadequacy of clinician engagement was evident in most LHDs. For example, one chair described a 'serious lack of engagement', while a senior executive confirmed 'poor recent engagement with clinicians', particularly with the Medical Staff Council. Another stakeholder provided the view that clinical engagement is 'variable across system'.

While clinicians do have some opportunities to engage through such mechanisms as representation on board subcommittees on healthcare safety and quality, there was less evidence of the deeper and broader engagement envisaged by Garling, by subsequent government policy and reform, and by the model by-laws.

¹³ For example, our performance audits on 'Medical equipment management in NSW public hospitals and Planning and evaluating palliative care services in NSW'.

The findings of this fieldwork are supported by our survey of board members. This survey found that over 90 per cent of respondents believed that medical and clinical councils should be 'extremely' or 'very important' to the functioning of an LHD. However, only 50 per cent of respondents felt that these councils were effective in their own LHD. Advice from medical and clinical councils was also the least valued of nine potential sources of advice for board decision making.

Board member comments raised issues about Medical Staff Councils specifically (noting that the *Health Service Act 1997* requires the chair of Medical Staff Councils be invited to attend LHD board meetings). These comments were:

- 'Our last Medical Council Chair barely attended board meetings.'
- 'Most Board meetings, there is no representative from the Medical Staff Council and this has had a cumulative detrimental effect on the Board/MSc members relationship.'
- 'Board decision making has not had sufficient input from MSC.'

Our review of board minutes confirmed that Medical Staff Council representatives are often not reported at board meetings.

The audit fieldwork and survey results were consistent with third-party sources, including:

- the 2016 Senior Hospital Doctor Survey¹⁴ conducted jointly by the Australian Medical Association and the Australian Salaried Medical Officers Association – this found that only 30 per cent of respondents felt that they were consulted on issues that affected them
- a survey conducted by the NSW Medical Staff Executive Council in 2017 found that 50 per cent of respondents reported poor or very poor engagement with their LHD board.

Ensuring appropriate clinician engagement should be the joint responsibility of LHDs, clinicians and the Ministry. There were a number of reasons suggested to explain the current degree of clinician engagement, including:

- the relatively fewer number of medical staff in smaller LHDs made it difficult to convene councils
- geography made it difficult for clinicians to attend these types of forums
- it can be difficult to engage part-time clinicians and visiting medical officers
- clinicians can struggle to find the time to participate
- clinicians have a natural aversion to engaging with administrators, whom they see as simply the 'holders of the money'
- clinicians become disillusioned if no-one listens to them, discouraging further participation
- the role of Medical Staff Council Chairs on LHD boards is unclear – are they just observers?

Governance attestation offers little assurance of clinician engagement

The NSW Health 'Corporate Governance and Accountability Compendium' explains that the structural reforms (devolution) to NSW Health '...demonstrated a strong commitment to devolve decision making to the local level and to actively involve clinicians... in public health services'.

The compendium also sets out Governance Standard 2, which requires that LHDs must ensure that 'effective forums are in place to facilitate the involvement of clinicians and other health staff in decision making at all levels of the organization'. LHDs complete annual attestation statements to confirm that they meet the expected minimum standards.

In each of the five LHDs selected for this audit, governance attestation statements against Governance Standard 2 only refer to the Medical and Dental Appointments Advisory Committee (and credentialing sub-committee). There are no references to the consultative bodies required under the model LHD by-laws.

¹⁴ The 2018 survey is in the field at the time of drafting this report.

Similarly, Governance Standard 6 requires LHDs to have, among other things, appropriate consultative strategies to involve staff (including non-clinicians) in decisions that affect them. Only one LHD included reference to staff consultation strategies in its 2017–18 statement.

2.3 Resolving ambiguity

There is a reliance on legislation and delegation manuals to resolve ambiguity

As discussed in Section 2.1, there is a good understanding of the respective roles and responsibilities of LHDs and the Ministry for their main functions. There is considerable confidence in NSW Health that legislation and delegation manuals can resolve any ambiguity that may arise in these roles and responsibilities. Legislation and delegation manuals are foundational features of large systems and in a simple and stable system, this confidence could probably be justified.

However, in a large, complex and dynamic system that is still evolving, this confidence is – by itself – insufficient. It is likely that functions and activities already exist that do not sit comfortably within existing formal responsibilities. These functions and activities need to be better supplemented by policy.

An area where this risk is pronounced is in the management and governance of innovation.

Roles and responsibilities for innovation

LHDs are encouraged to be innovative to improve how they deliver services. This takes many forms across LHDs including dedicated functions for 'innovation', 'research', 'translational research', 'business transformation' and 'continuous improvement'. Continuous improvement is also an important objective of the clinical governance function.

In each of the LHDs we visited, there was a clear appetite for innovation and a range of activities and initiatives. Examples included:

- almost all LHDs were contemplating or had established innovation hubs
- some were developing programs of work around 'big data' and data analytics
- others were able to point to examples where local innovations had been adopted more widely, such as in the Leading Better Value Care initiative
- some LHDs have dedicated plans and frameworks, such as the Research, Innovation and Change Plan developed by Murrumbidgee LHD (and supported by a Research, Innovation and Change Board sub-committee)
- dedicated programs exist to try to promote innovation in a coordinated way, such as the 'The Inspiring Idea Challenge' at South Eastern Sydney LHD.

However, the audit did not find generally applicable principles or rules to determine when innovation falls within an LHD's roles and responsibilities, and when it should be addressed elsewhere in the system.

While LHDs are encouraged to be innovative, when pursued independently across 15 LHDs and without any overall innovation governance, there are LHD and system risks such as:

- duplication of effort
- inefficiency and expense
- an individual LHD's lack of specialised skills and capability
- lack of scalability or transferability
- failure to share the innovation
- failure to share learnings and good practice.

As one chief executive within NSW Health explained: 'we should build once what only needs to be built once, and share what can be done separately'. Another chief executive noted the history within the NSW public health system of IT systems that are not interoperable – even within LHDs.

Better overall innovation governance for LHDs would assist to mitigate these risks. There are existing resources that could inform a framework or set of principles to guide how LHDs manage innovation as a function. These resources include:

- NSW Health's existing 'Framework for New Health Technologies and Specialised Services' – this provides a process and principles for LHDs considering implementing new technologies or services that are not adopted for use at a state-wide level.
- NSW Health's Office of Health and Medical Research provides a useful checklist for translation research grants applicants – while intended for a different purpose, some of the issues that the applicant must consider seem relevant to any assessment of whether an innovation should be pursued.

In addition, a key determinant of where responsibility for innovation sits – or any function where responsibility may be blurred – is the alignment of risk tolerance between LHDs and the Ministry. The extent to which there is alignment, is likely to impact what functions are devolved to LHDs.

A statement of principles is needed to guide devolution

A statement of principles about the scope and limits of devolution may assist in the maturing of governance arrangements for LHDs. A principle-based approach offers the benefit of providing broadly-applicable guidance for decision making.

In a complex system, this approach is likely to be preferred over attempting to anticipate and respond to every conceived or emerging scenario with individual prescriptive rules. Principle-based privacy regulation provides one such model, whereby an act or practice is permitted (or not), subject to the applicability of exceptions.

For example, one simple principle that could guide decision making in a devolved system might be:

- Decisions about public health services are made locally, except where expressly indicated to the contrary by:
 - law
 - government policy or
 - system-wide strategy.

Risk tolerance should play an important part in determining how much is permitted to be devolved, as should the overall governance capability and maturity of system participants.

2.4 The functioning of governance committees within LHDs

Board committees provide rigorous and thorough oversight

Part 12 of the NSW Health LHD model by-law requires that boards must establish committees for:

- Audit and Risk
- Finance and Performance
- Quality and Safety
- any other committees that the board determines appropriate.

The audit focused on the three mandatory committees in the model by-laws.

These committees work effectively in providing rigorous and active oversight of their respective subject areas. These committees provide more detailed scrutiny of their focus areas than the board can offer. Senior executives also submitted that the quality of discussion in committees has matured: 'they now discuss substance, not just housekeeping'.

Board and committee meeting papers show that there is substantial sharing of information between the committees, including mechanisms to distribute agendas and minutes.

In LHDs where they were available, detailed committee minutes show that these committees exercise their functions rigorously and ensure that LHD management is held to account for their areas of responsibility.

Charters of these committees address key elements of good committee practice, such as specifying lines of accountability, review mechanisms, dispute resolution mechanisms, and requirements for induction and training of new members. Southern NSW LHD also included 'indicators of effectiveness' in committee charters, a seemingly useful addition.

There were minor aberrations or inconsistencies across committees, including:

- while most charters established that Audit and Risk Committees are responsible to the board, in one instance this responsibility was to the chief executive – it is unclear why this is the case, though may be a result of uncertainty about the meaning of 'agency head' in the NSW Treasury model charter
- while most do, not every charter includes a requirement to review the performance of the committee or the adequacy of the charter
- while the high-level focus of this audit did not invite detailed review of compliance with charter provisions, it was apparent that at least some reviews are overdue.

Better clarity could be achieved between board committees in overseeing risk

One area of potential uncertainty was evident in the relationship between Audit and Risk Committees and Safety and Quality Committees. Audit and Risk Committees generally view clinical risk as being within their remit. This creates a form of overlap with the remit of Safety and Quality Committees.

Currently, any uncertainty or tension is resolved by liaison between the two committee chairs – effectively relying on the goodwill of the individuals in the two positions. Clear guidance or protocols are required to reduce the risk of conflicting or inconsistent decision making, and to clarify the relationships and responsibilities between the committees.

2.5 Managing issues at an appropriate level

Devolution principles generally work appropriately for key functions

As discussed in Section 2.3, most decisions in the public health system are made at a level that is consistent with roles and responsibilities. The delivery of day to day health services is left to LHDs in a way that is consistent with their functions under legislation, while the Ministry manages the system and performs monitoring and oversight.

There were examples provided of perceived Ministry over-reach into operational matters. For example, in four LHDs, concerns were raised about potentially locally inappropriate models of care being imposed on day to day health service delivery under the Leading Better Value Care program.

At the same time, there were notable examples of where the Ministry effectively coordinated cross-LHD initiatives – including the Patient Flow Collaborative and a cross-LHD ICU initiative.

Clearer articulation of when, or in what circumstances, the Ministry assists or leads in these programs, and when they fall within LHD operational responsibilities, would ensure greater clarity of LHD functions. As discussed in Section 2.3, this could be done by principles to guide decision making in a devolved system.



3. Accountability and oversight



Accountability and oversight mechanisms, including the Health Performance Framework and service agreements, have been effective in establishing accountability, oversight and strategic guidance for LHDs. They have done this by driving a cultural shift that supports LHDs being accountable for meeting their obligations. These accountability and oversight mechanisms must continue to evolve and be improved.

This cultural shift has achieved greater recognition of the importance of transparency in how well LHDs perform. However, as NSW Health is a large, complex and dynamic system, it is important that these accountability and oversight mechanisms continue to evolve to ensure that they are sufficiently robust to support good governance.

There are areas where accountability and oversight can be improved including:

- continued progress in moving toward patient experience, outcome and value-based measures
- improving the Health Performance Framework document to ensure it is comprehensive, clear and specifies decision makers
- greater clarity in the nexus between underperformance and escalation decisions
- by adding governance-related performance measures to service agreements
- more rigour in accountability for non-service activity functions, such as consumer and community engagement
- ensuring that performance monitoring and intervention is consistent with the intent of devolution.

Recommendations

3. By June 2020, the Ministry of Health should improve accountability and oversight mechanisms by:
 - a) revising the Health Performance Framework so that it is a cohesive and comprehensive document
 - b) clarifying processes and decision making for managing performance concerns
 - c) developing a mechanism to adequately hold LHDs accountable for non-service activity functions
 - d) reconciling performance monitoring and intervention with the policy intent of devolution.

3.1 Service agreements

Service agreements provide accountability and direction for LHDs

Service agreements are made annually between each LHD and the Ministry, and are published on LHD websites. These agreements are the instrument used by NSW Health to:

- articulate the strategic priorities for the health system
- recognise specific local priorities
- set performance and accountability requirements for health services.

Service agreements follow a standard template and much of the content is the same for each LHD. Common content includes:

- a reiteration of NSW Health values (Section 2)
- statements of expectation around culture and engagement (Section 3)
- an outline of related governance obligations and instruments (Section 4)
- a statement of strategic deliverables or priorities from the Ministry (Schedule A).

Content that is unique to each LHD includes:

- a statement of locally determined priorities for that year (contained in Schedule A)
- an outline of the services and facilities under the governance of, or supported by, the LHD (Schedule B)
- an annual budget (Schedule C)
- negotiated purchased volumes of activity (Schedule D).

A schedule of key performance indicators is attached to Service Agreements at Schedule E. LHDs' performance against these indicators is monitored under the NSW Health Performance Framework.

'The DNA of the agreement enters the LHD'

Service agreements are valuable documents that serve a number of functions. Individuals with longer experience in the public health system contrasted the service agreement model very favourably to the arrangements that existed historically, whereby control of the system was much more centralised, considerably more opaque, and less responsive to local needs.

Service agreements also clearly establish the expectation that LHDs will be accountable for delivering those things for which they are responsible. They have supported a cultural shift in expectations about how transparent and accountable health services should be to their stakeholders – one chief executive reminds staff, 'we are a health service, not a secret service'. Service agreements help to embed this expectation. This accountability is enhanced by service agreements being published on LHD websites.

Additionally, the high-level strategic direction encapsulated in the service agreements highlights how system objectives cascade down to LHD strategic and operational plans. Because so much LHD activity is driven by service agreements, one chief executive expressed the view that even if staff do not routinely review the document, the 'DNA of the agreement enters the LHD'.

The process of developing and negotiating service agreements has evolved and matured since they were first introduced. Both Ministry staff and individuals in LHDs were able to describe a consistent understanding of a clear process that is followed to prepare service agreements. LHDs are provided with a schedule of key activities and dates to guide their planning and engagement in process. This process has also:

- encouraged the Ministry to engage more openly with LHDs – as part of the process, the Ministry conducts workshops and roadshows with LHDs, which gives the Ministry 'connection with the coalface'
- encouraged a greater – though still imperfect – sense of transparency around how activity and pricing are determined by the Ministry.

Purchasing Framework effectively supports the service agreement process

The NSW Health Purchasing Framework is effective in supporting the service agreement negotiation process, as well as the NSW Health Performance Framework. This framework is intended to help determine the annual mix and volume of services that should be purchased from LHDs to achieve NSW Government and NSW Health objectives.

In addition to bringing together the various high-level system objectives, the Framework sets out a process by which activity targets are developed, including the factors that are considered in setting the targets. These factors are reviewed and negotiated annually and are intended to ensure that activity targets are determined with greater sophistication than simply being rolled-over with a constant growth factor added.

The service agreement process can be improved

The service agreement process has developed in recent years, including through a more well organised and transparent process, as well as more sophisticated and maturing approach to negotiation. However, there are areas where further progress could be achieved, including to:

- ensure greater transparency and understanding among LHDs about how activity, pricing, and own source revenue targets are determined
- engage further with those LHDs that provide services outside the metropolitan areas of Sydney-Newcastle-Wollongong to ensure that the funding formula is appropriate.

As discussed in Section 2, the proper role of the LHD boards in the service agreement process also remains a point of uncertainty.

There are no governance-related performance measures in service agreements

Service agreements purport to set out performance measures for LHDs against each of the eight NSW Health Strategic priorities. Strategy 8 is to 'Build Financial Sustainability and Robust Governance'. Notably, each of the key performance indicators under this strategy relate to financial sustainability; there are no performance measures of good governance.

While good governance does not readily lend itself to meaningful quantification, there are proxy or lead indicators that may suggest that an LHD is likely to have 'robust governance'. These could include such matters as:

- the number of overdue internal audit items
- the number of matters formally raised to the board by the staff councils
- rates of board and committee member attendance
- the proportions of overdue reviews of boards, committees, members, and charters.

Better information is needed about commitments for local priorities

As well as expressing activities, volumes and prices negotiated with the Ministry, service agreements also provide a statement of local priorities selected by LHDs. These local priorities are usually from LHD strategic plans or, in turn, operational plans, and should provide a simple, specific, consolidated list of what the LHD will achieve or progress in that year.

Being responsive to local needs, and engaging with local patients, carers and communities, are important requirements of LHDs – indeed, these are some of the key intended benefits of devolution. Local priorities are how LHDs fulfil these functions.

Often, the detail included in service agreements about local priorities is inadequate to provide transparency or accountability, either for the benefit of local communities or to meet the Ministry's role in monitoring LHD performance.

For example, one LHD included in its 2017–18 Service Agreement a one-page 'District Strategy Map' as its statement of local priorities for that year. This map included 18 strategic goals. These were expressed in high-level aspirational terms such as to 'Improve the patient's experience of care' and 'Support a healthy start to life'. No further information was provided on what these goals mean, why they were chosen, what key tasks will be done, or how success or progress will be measured. Other service agreements include not more than a handful of simple dot-points.

A better model might include a brief description of the priority, including a small number of key tasks for that year, target milestones, and an indication of how progress will be measured.

Similar issues have been identified elsewhere, such as the future priorities included in LHDs' quality and safety accounts. These 'accounts' are effectively annual reports submitted by LHDs to the Ministry explaining initiatives undertaken to improve the safety and quality of care.

The Ministry found that '...some districts provide limited detail on their priorities and why their priorities were selected', while more useful reports were those that 'gave quite specific priorities, why they were chosen and what they endeavoured to achieve'.

Timeliness of signing and returning service agreements has improved

The Auditor-General has previously noted delays in LHDs signing and returning service agreements by 31 July. For 2018–19, 11 of 15 LHDs signed and returned their agreements on time. This is a considerable improvement from the six LHDs in 2015–16.

3.2 The NSW Health Performance Framework

There are three main performance reporting tools

The NSW Health Performance Framework is focused on monitoring, reporting and, where necessary, responding to performance issues relating to the key performance indicators set out in the service agreements made between LHDs and Ministry.

Routine monitoring and reporting is done through three tools, as described below:

- Monthly system-wide performance reports provided to each LHD.
- Quarterly performance meetings with each LHD.
- Six-monthly reviews of strategic priorities.

These reporting tools are detailed in Appendix four.

There is progress in developing better performance indicators

The performance measures reported under the Performance Reporting Framework are those set-out in Schedule E of each LHD's service agreement. Each of these are linked to one of NSW Health's eight strategic priorities. The performance measures are broadly in line with those adopted in other states, which allows for comparisons of performance with other jurisdictions for many performance measures.

As noted in the NSW Health's 'System Purchasing and Performance Safety and Quality Framework', performance measures in health '...have been traditionally based around routinely collected data'. This application of administrative data to health system measurement is not always ideally fit-for-purpose. The audit has found that considerable effort is going toward providing more meaningful performance measures.

These more meaningful performance measures are focused at measuring consumer experience and patient reported outcomes, as well as measures for safety and quality of care.

This is particularly evident as part of the Leading Better Value Care program, which is being driven by a desire to focus on value, rather than volume, in health service delivery. While interviewees expressed disappointment that the first tranche of eight initiatives under the Leading Better Value Care program still rely on volume-based performance measures, these are expected to evolve to more outcome-focused measures as the program progresses to its second tranche of initiatives.

The Health Performance Framework promotes awareness of accountability and transparency

The Health Performance Framework has been effective in establishing expectations about performance monitoring in LHDs. There is a clear understanding in LHDs that:

- their performance is monitored by the Ministry
- there can be consequences for under-performance
- the consequences are linked to the Ministry's assessment of the materiality of the under-performance
- part of the response to an unfavourable assessment may include being 'escalated' to a level from one to four.

In most regards, the framework is consistent with equivalent frameworks in other Australian states.

As with service agreements, the Performance Framework plays an important role in setting expectations that LHDs are held accountable for the outcomes they achieve by the transparent reporting of their performance.

The Health Performance Framework could be made more comprehensive, clear, and practical

While the Performance Framework has contributed to a cultural shift in attitudes around accountability and transparency, it would be consistent with a maturing system to address several significant issues with its content, structure and operation.

First, the Performance Framework does not appear to fully reflect developments in the performance monitoring and reporting environment. It does not mention the Emergency Treatment Performance (ETP) Watch List or Elective Surgery Access Performance (ESAP) Performance Monitoring and Recovery Support Program.¹⁵

It also does not reference any additional performance monitoring conducted in real-time for Transfer of Care, nor the reporting done annually by LHDs for their quality and safety accounts.

These omissions mean that the Performance Framework is not accurately reflecting all the performance reporting that is performed, nor showing how (or if) this reporting fit together in a cohesive and comprehensive reporting environment.

Second, there is considerable scope to more clearly explain how the elements of the Performance Framework come together. For example, on page 4 of the Performance Framework document, there is a list of nine dot points introduced by the sentence 'The operation of the framework involves'. It is unclear if the dot points are intended to reflect a logical step by step process or a statement of objectives.

Similarly, the relationship is unclear between the eight 'criteria' for performance concerns on page 7 and the indicators of a 'health service's overall performance' on page 8 of the Performance Framework document.

Third, the Performance Framework appears to rely heavily on subjectivity and judgment for what are essentially forms of regulatory decisions. This is a weakness common to most health performance frameworks in Australia. This is discussed further below in Section 3.3. Notably, the Framework does not specify decision-makers – given these decisions come with considerable discretion on the part of the decision-maker, it is important to specify who has this responsibility.

Sharing good practice – closing the loop

While the Performance Framework provides a mechanism to identify good 'performance' in LHDs, there is less focus on identifying and sharing good 'practice'. Agencies like the ACI and CEC are generally well-regarded for their efforts in disseminating good practice from their priority areas, but it is harder for LHDs to elevate and share good practices beyond their own borders – indeed, the audit came across examples of good practice in individual hospitals that had not even been shared within the same LHD.

The Health Performance Framework mentions sharing good practice, but does not set out any mechanism – nor link to any mechanism – that would do this. The monthly or quarterly performance interactions do not include actively seeking feedback from high-performing LHDs on their good practice – even in monthly reporting letters where LHDs were recognised for 'excellent' performance, there was no enquiry about the good practice that was driving that excellence. The NSW Health annual awards provide important recognition to LHDs that perform well, and may offer some opportunity to increase awareness of good performance, though any sharing is likely to be opportunistic.

In interviews, there was a recognition that sharing good practice requires far more attention as part of overall governance arrangements between LHDs and the wider system. One chief executive in

¹⁵ It is expected that further guidance on how these programs work will be provided in an anticipated 'Performance Recovery Framework' currently (at the time of the audit) being prepared by the Ministry.

the NSW health system described improving organisational capacity to share learnings as “a priority for moving LHDs along the 'maturity curve'”.

The lack of attention to sharing good practice is common to health performance frameworks across Australia. The frameworks in Victoria, Western Australia and Tasmania do not mention good practice. The frameworks of Queensland and South Australia both refer to the desirability of sharing good practice, but neither say how this might be done.

What gets done is not always what gets measured

In addition to service activity functions, there are non-service activity functions that LHDs are required to perform. These functions include engaging with and responding to local communities, building relationships with local primary care networks and NGOs, as well as being innovative. Because these functions are less tangible, they can be ill-suited to conventional performance measurement.

These are important obligations on LHDs, though the Health Performance Framework, including service agreements, are comparatively silent on how LHDs are held to account for whether they do these functions.

Greater clarity about how LHDs are held accountable for non-service activity functions – including to their own boards, which were not always able to demonstrate how they maintained line-of-sight over local functions and initiatives – would be a valuable contribution to the ongoing maturity of the performance management system that strives to promote accountability and transparency.

Ensuring accountability for community and consumer engagement

There were impressive examples of consumer and community engagement initiatives and models in each of the LHDs included in this audit. This engagement is important. Boards have legislative functions to seek the views of – and provide advice to – consumers and their communities on district policies, plans and initiatives. This obligation is also built into service agreements.

Despite the importance of community and consumer engagement, it remains underdeveloped in existing governance arrangements, including the accountability mechanisms. It is difficult for boards or the Ministry to know with confidence that community and consumer engagement is being done effectively. If devolution was intended to bring the management of health services closer to local communities, then there is little way to know whether this is being achieved.

However, there are examples of better practice.

For example, the South Eastern Sydney LHD's Mental Health First Aid Youth Program was developed as a result of that district's inter-sectorial Board of Community Partnerships Committee (BCPC). Regular monitoring and evaluation of the quality and efficacy of the program partnership was essential to support the Implementation Group to action an effective youth mental health program. The evaluation tool was the Victorian Health Partnerships Analysis Tool, a resource designed for organisations working in partnerships to assess, monitor and maximise its ongoing effectiveness.

Similarly, at Hunter New England LHD, the effectiveness of all 46 local community partnerships are evaluated annually and reported to the board's community partnerships committee.

While there are other examples where LHDs report on their community and consumer engagement, these are often descriptions of activity, with no assessment of outcome, objective, risks, status or progress.

This includes for the purpose of accreditation under Standard 2 of the mandatory National Safety and Quality Health Service Standards. Standard 2 requires evidence of health services having included consumers in the development and design of quality health care. However, this standard is about process, not outcomes; as one stakeholder noted, 'it does not reveal if engagement is tokenistic or ineffective'.

In addition to more mature and robust methods of promoting accountability for consumer and community engagement, other issues with this function include:

- lack of opportunities and capacity to share good practice across LHDs
- lack of engagement by the Ministry to set expectations about what is required and to assist with capacity-building.

3.3 Performance intervention

There can be greater clarity around triggers for escalation and intervention

LHDs may be 'escalated' by the Ministry in response to performance concerns. The Health Performance Framework includes a model that is intended to show what happens at each 'point of escalation' (see Appendix five). It does not explain how a point of escalation is determined, other than to suggest that 'governance and management failures', along with sentinel events, are automatically escalated to level 2.

LHDs may also be subject to performance intervention through focused programs, including:

- The Emergency Treatment Performance (ETP) Watch List Monitoring and Recovery Strategy – hospitals that underperform by more than a specified threshold over three months are put on this program to foster performance recovery.
- The Elective Surgery Access Performance (ESAP) Performance Monitoring and Recovery Support Program assist hospitals that have significant numbers of overdue patients. This includes weekly reporting and attendance at teleconferences to discuss the number of overdue patients and local strategies to address identified issues.

LHDs understand that there is the possibility of escalation and intervention by the Ministry in response to performance concerns. It is not contentious that material underperformance should trigger a response from the Ministry, as system manager.

However, LHDs are less certain about how any given performance concern results in escalation (or de-escalation) to a particular level. This process was described as 'opaque', and it was suggested that it 'needs to be more objective'. A number of interviewees who had been involved in these processes did not understand how the decision to escalate had been reached, including what factors had been taken into account, and what relative weight was attached to different factors.

While some judgement will always be exercised about the relative materiality of a performance concern (particularly in taking account of contextual factors), it would be consistent with good regulatory practice for this process to be as transparent, predictable and consistent as possible.

Performance frameworks in other states also largely fail to explain how decisions are made about escalating a performance concern and intervening in a health service's functions. The exceptions to this are Victoria and Tasmania, both of which offer decision making models that explicitly link the escalation decision to an assessment of risk. The relative simplicity of the Tasmania approach contrasts with a complex and engineered decision-making model used in Victoria.

In response to performance concerns, the Ministry has some capacity to help LHDs through the System Performance Support Branch, which provides support across a range of areas, including in service delivery and financial performance. This is a valuable resource for LHDs, as demonstrated by its work in leading the Patient Flow Collaborative. However, there is scope for LHDs to make greater use of the support that is available, including to address emerging performance issues before they require formal intervention under the Health Performance Framework. This would be aided by a better understanding among LHDs of how this resource is prioritised and allocated across the health system.

Monitoring and intervention should support the intent of devolution

The Ministry conducts more active forms of performance monitoring and intervention, including effectively real-time monitoring and intervention of some activities (most notably, ambulance and emergency department performance).

To ensure a comprehensive framework, it would be useful to include reference to this real-time monitoring as part of the Health Performance Framework (similarly with the 'watch list' programs for emergency departments and elective surgery performance).

Where real-time data, monitored on electronic boards in Ministry offices, show an emerging or actual performance issue, contact is made with the respective LHD or hospital to highlight concern. LHDs have commonly adapted to this arrangement by proactively contacting the Ministry before problems become performance issues.

This process embeds a system of routine performance surveillance at a granular-level that risks undermining the capability of clinicians and other decision makers to manage services locally, in turn hampering the further maturing of the system.

LHDs have responsibility for managing their day to day operations independently, even when pressed. Their own systems and staff must be sufficiently capable to identify and respond to emerging pressures and not, as one interviewee expressed it, be '...dependent on the continuous vigilance of performance monitoring'.

There is also a risk that these interventions may be perceived as being driven by political or media considerations, rather than clinical need.

In contrast, there is a seemingly clearer and more valuable role for the Ministry to intervene to assist in facilitating system-wide responses to emergencies, such as influenza outbreaks. The Ministry also performs this system coordination function effectively in encouraging LHDs to prepare 'winter plans', and then in coordinating a review and 'lessons learned' exercise at the end of the season.

The Ministry also assists by being responsive to emerging performance concerns raised by LHDs, particularly where coordination may be required across LHDs borders or where approval is required to temporarily depart from an LHD's Patient Allocation Matrix.¹⁶

Sections 2.3 and 2.5 of this report discuss the potential value of establishing principles to guide the implementation of devolution, including in making decisions about the extent and scope of decision making and accountability between the Ministry and LHDs. Such principles could help to ensure that performance monitoring and intervention measures applied by the Ministry remain consistent with the policy intent of devolution.

¹⁶ The NSW Health Patient Allocation Matrix determines the nearest, most clinically appropriate Emergency Department (ED) for all patients arriving by ambulance.

Section two

Appendices



Appendix one – Response from agency



Ms Margaret Crawford
NSW Auditor-General
Audit Office of NSW
GPO Box 12
SYDNEY NSW 2001

Our ref H19/21809

Dear Ms Crawford

Performance Audit report on Governance of Local Health Districts

Thank you for inviting NSW Health to provide comment on the recommendations made in the final performance audit report on Governance of Local Health Districts.

The recommendations made in the report are welcomed. NSW Health operates within a complex governance and performance framework, established through a layering of legislation, policy and practice. This framework is continually evolving and the recommendations presented align with our commitment to the continuous improvement of the NSW Health System. Within this context, please find attached a table detailing NSW Health's response to each individual recommendation.

I would also like to specifically address the following observations made in the report:

The role of the Ministry of Health in overseeing patient access to critical services
In its capacity as the System Manager, the Ministry of Health monitors the performance of Local Health Districts to ensure the accessibility and high performance of services. A defined escalation process is in place which is designed to maintain management of significant patient flow issues impacting Local Health Districts. The escalation process allows for, in the first instance, local resolution of patient flow issues and an avenue to escalate to the Ministry to allow for a coordinated system response when required. This process facilitates greater collaboration between NSW Health Organisations and is driven by a commitment to patient safety and care. Success of the escalation pathway is demonstrated in the significant improvements in releasing ambulance resources from emergency departments. The escalation process has improved the time taken to transfer patients from paramedics to emergency department staff, leading to a demonstrated saving of 130 paramedic hours per day since 2014-15 and ensures quicker access for patients to emergency care.

The implementation of the Leading Better Value Care program
The report highlights NSW Health's Leading Better Value Care program and offers observations regarding the perceived boundaries between the roles of the Ministry of Health and the Local Health Districts in its implementation which need to be clarified. This program is one of the ways in which NSW Health is moving towards value based healthcare, taking a state-wide approach to designing, implementing and embedding clinically led evidence-based and patient-centred models of care. As part of this, the Ministry of Health provides a vision and framework within which Local Health Districts and Specialty Health Networks plan and implement approaches according to local circumstances. In its role as the System Manager, the Ministry of

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Health facilitates the sharing of successful models in order to refocus activity to improve outcomes for patients and does not seek to impose models of care at the local level.

Enhancing our engagement with Clinicians

Engagement with clinicians and our highly skilled professional staff is essential to the overall success of our Health System. The report finds that work remains to be done on enhancing our approach to engagement and this observation is accepted within context of guiding the continuous improvement of our governance framework. I would highlight the work being undertaken within the Tunning Governance and Accountability project, which is focusing on testing engagement structures and developing a renewed model to drive ongoing improvement in this area.

I appreciate the collaborative approach adopted by your officers in undertaking the audit by engaging and working closely with the Ministry, the Boards and the Local Health Districts in the course of the audit.

Yours sincerely



Elizabeth Koff
Secretary, NSW Health

10/4/19

No.	Audit Recommendation	Response	Comment
1	By December 2019, the Ministry of Health should:		
1a	Work with Local Health Districts to identify and overcome the barriers that are limiting the appropriate engagement of clinicians in decision making in Local Health Districts.	Accepted	The Ministry of Health is currently implementing the Tuning Governance and Accountability project, with the objective of engaging Local Health Districts and other NSW Health Organisations in identifying and strengthening core areas of governance. The topic of effective engagement with clinicians is highlighted in the project as the next topic area for delivery.
1b	Develop a statement of principles to guide decision making in a devolved system.	Accepted	As for 1a, the Tuning Governance and Accountability project will also be seeking to define a core set of governance principles for application across the NSW Health System, complementing the existing resources currently available to all NSW Health Organisations.
1c	Provide clarity on the relationship of the Agency for Clinical Innovation and the Clinical Excellence Commission to the roles and responsibilities of Local Health Districts.	Accepted	As for 1a and 1b, the Tuning Governance and Accountability project is currently focused on clarifying the roles of NSW Health Organisations, Executive and Boards and the relationships they share in delivering high performing services to patients.
2	By June 2020, Local Health District Boards, supported where appropriate by the Ministry of Health, should address the findings of this performance audit to ensure that local practices and processes support good governance, including:		
2a	Providing timely and consistent induction; training; and reviews of Boards, members and charters.	Accepted	In addition to clarifying the role of Boards in 1a, 1b and 1c, a renewed Board orientation program and complimentary resources for all Board members are currently being developed and will be implemented within the specified timeframe.
2b	Ensuring that each Board's governance and oversight of Service Agreements is consistent with their legislative functions.	Accepted	The role of Local Health District Boards in reviewing Service Agreement content and their accountabilities with regard to oversight of performance will be considered as part of the regular review of the NSW Health Performance Framework and the delivery of the objectives of the Tuning Governance and Accountability project.
2c	Improving the use of performance information to support decision making by Boards and executive managers.	Accepted	The Ministry is currently piloting a performance dashboard for Local Health District Boards with the objective of strengthening the use of performance data to inform oversight of activity. This recommendation will be considered as part of the review of the outcomes of the pilot program before progressing to full implementation.

No.	Audit Recommendation	Response	Comment
3	By June 2020, the Ministry of Health should improve accountability and oversight mechanisms by:		
3a	Revising the NSW Health Performance Framework to ensure it is cohesive, clear and comprehensive.	Accepted	The Ministry of Health regularly reviews the application of the NSW Health Performance Framework to ensure that it continues to drive safety and quality outcomes, aligns with the purchasing model and provides a robust, transparent and supportive framework for the delivery of services. The points raised will be included as part of this review process.
3b	Clarifying processes and decision making for managing performance concerns.	Accepted	As for 3a.
3c	Developing a mechanism to adequately hold LHDs accountable for non-service activity functions.	Accepted	The Ministry of Health will consider opportunities to identify and define additional non-service functions for oversight, with the recognition that variation currently exists within the NSW Health Performance Framework in order to ensure local services can be tailored to meet local demands.
3d	Reconciling performance monitoring and intervention with the policy intent of devolution.	Accepted	As for 3a.



Appendix two – Functions of a Local Health District

The functions of a LHD are as follows:

- a) generally to promote, protect and maintain the health of the residents of its area
- b) to conduct and manage public hospitals, health institutions, health services and health support services under its control
- c) to give residents outside its area access to such of the health services it provides as may be necessary or desirable
- d) to achieve and maintain adequate standards of patient care and services
- e) to ensure the efficient and economic operation of its health services and health support services and use of its resources
- f) generally to consult and co-operate (as it considers appropriate) with any one or more of the following:
 - i) the Health Care Complaints Commission constituted under the *Health Care Complaints Act 1993*
 - ii) health professionals practising in its area
 - iii) other individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the promotion, protection and maintenance of health
- f1) to co-operate with other LHDs and the Health Secretary in relation to the provision of services involving more than one public health organisation or on a state-wide basis
- g) to investigate and assess health needs in its area
- h) to plan future development of health services in its area, and, towards that end:
 - i) to consult and plan jointly with the Ministry of Health and such other organisations as it considers appropriate
 - ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services
 - iii) to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister
- i) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services
- j) to provide services to persons with whom it has contracted or entered into an agreement under section 37 (2)
- k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129
- l) to provide training and education relevant to the provision of health services
- m) to undertake research and development relevant to the provision of health services
- n) to make available to the public information and advice concerning public health and the health services available within its area
- o) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.



Appendix three – Functions of a Local Health District Board

1. The Local Health District Board for a LHD has the following functions:
 - a) to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the LHD and to approve those frameworks
 - b) to approve systems:
 - i) to support the efficient and economic operation of the local health district
 - ii) to ensure the district manages its budget to ensure performance targets are met
 - iii) to ensure that district resources are applied equitably to meet the needs of the community served by the district
 - c) to ensure strategic plans to guide the delivery of services are developed for the LHD and to approve those plans
 - d) to provide strategic oversight of and monitor the local health district's financial and operational performance in accordance with the state-wide performance framework against the performance measures in the performance agreement for the district
 - e) to appoint, and exercise employer functions in relation to, the chief executive of the local health district
 - e1) to ensure that the number of NSW Health Service senior executives employed to enable the LHD to exercise its functions, and the remuneration paid to those executives, is consistent with any direction by the Health Secretary or condition referred to in section 122 (2)
 - f) to confer with the chief executive of the LHD in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement
 - g) to approve the service agreement for the LHD under the National Health Reform Agreement
 - h) to seek the views of providers and consumers of health services, and of other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services, and to confer with the chief executive of the district on how to support, encourage and facilitate community and clinician involvement in the planning of district services
 - i) to advise providers and consumers of health services, and other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services
 - j) to endorse the local health district's annual report
 - k) to liaise with the boards of other LHDs and specialty network governed health corporations in relation to both local and state-wide initiatives for the provision of health services
 - l) such other functions as are conferred or imposed on it by the regulations.
2. A LHD board must not exercise a function in a way that is inconsistent with the exercise of a function by the Health Secretary (including a function that has been delegated to the Health Secretary).



Appendix four – Routine performance monitoring and reporting

The NSW Health Performance Framework provides that routine monitoring and reporting is done through three mechanisms, as described below.

- Monthly system-wide performance reports provided to each LHD – the Ministry considers this as the primary formal reporting tool for LHD performance against service agreements. The reports sighted by the Audit Team focused on a narrow range of performance measures, specifically:
 - Emergency Department performance
 - Transfer of Care performance (from ambulances)
 - Elective surgery waiting times performance
 - The provision of timely notification to the Ministry of reportable incidents
 - A very high-level summary of the individual LHD's financial performance.
- Quarterly performance meetings with each LHD – Every three months, each LHD meets with the Ministry to discuss performance against a broader range of indicators. These sessions can also include focused sessions on particular topics, and LHDs may provide updates on their progress against strategic priorities.
- Six-monthly reviews of strategic priorities – each health service is required to report progress on their strategic priorities on a six-monthly basis.

In addition, the Framework sets out four performance escalation levels, from level 0 ('no performance issues') through to level 4 ('health service challenged and failing'). The escalation model is discussed further in Section 3.3.



Appendix five – Escalation model for the NSW Health Performance Framework

Point of escalation	Point of de-escalation	Response
Level 0 - 'No performance issues'		
Level 1 - 'Under review'		
Performance issue identified	The issue is satisfactorily resolved.	<p>The health service chief executive will provide formal advice to the Ministry on:</p> <ul style="list-style-type: none">• the factors that led to the performance issue• the intended action to be taken to rectify the performance issue• the timeframe to achieve the recovery.
Level 2 - 'Under-performing'		
<p>The original performance issue that triggered a Level 1 response has not been resolved.</p> <p>Other performance issue(s) emerge warranting Level 2.</p> <p>A governance or management failure or sentinel event occurs warranting escalation to Level 2.</p>	The performance issue/s are resolved and do not re-emerge.	<p>The health service will:</p> <ul style="list-style-type: none">• undertake an in-depth assessment of the problem and identify options to address the problem• provide a detailed recovery plan and a timetable for resolution. The plan is signed off by the board• meet with the Ministry to formally monitor the recovery plan. The time frame for recovery will be as agreed with the Ministry.

Point of escalation	Point of de-escalation	Response
Level 3 - 'Serious under-performance risk'		
Additional support and involvement required from the Ministry, e.g. diagnostic assessment		
Response The recovery plan is not progressing well and is unlikely to succeed without additional support and input from the Ministry.	The revised recovery strategy has succeeded and the performance issue shows no indication of re-emerging in the ensuing three months.	<p>The health service is to develop a recovery strategy satisfactory to the Ministry of Health. The Ministry may require the strategy to include assigning staff identified by the Ministry to work collaboratively with the health service to develop and implement the strategy; or to have a more direct involvement in the operation of the health service.</p> <p>The Ministry may appoint a representative for the specific purpose of assisting the board to effectively oversee necessary performance improvements including attending board meetings for that purpose.</p> <p>The timing and scope of any action will be determined by the nature of the performance issues.</p>
Level 4 - 'Health Service challenged and failing'		
Changes to the governance of the health service may be required		
The recovery strategy has failed and changes to the governance of the health service may be required.	The performance issue has improved and there is demonstrable evidence that the health service now has the capability to have full responsibility for the operation of the service.	<p>The timing and scope of any action will be determined by the nature of the performance issues*. These may include:</p> <ul style="list-style-type: none"> the Secretary of Health commissioning an independent review of health service governance and management capability the Minister requiring the board chair to demonstrate that the CE is able to achieve turnaround within a reasonable time frame the Minister determining to change the membership of the board and/or appointing an administrator.*

* Nothing in this document is to be taken as affecting or limiting the discretion to exercise powers under sections 29, 52 or 121N of the Health Services Act.



Appendix six – About the audit

Audit objective

The audit objective is to assess the effectiveness and efficiency of the governance of LHDs.

Audit criteria

We addressed the audit objective with the following lines of enquiry.

1. Are there clear roles, responsibilities and relationships between the Ministry of Health and LHDs and within LHDs?
 - Holders of governance-related roles within the Ministry of Health and LHDs understand and fulfil their roles and responsibilities.
 - Holders of governance-related roles maintain professional and effective relationships.
 - Ambiguity in roles and responsibilities is resolved with reference to devolution principles.
 - Key governance committees work cohesively within LHDs.
 - Issues are effectively escalated and resolved at an appropriate level in NSW Health.
2. Does the NSW Health Performance Framework establish and maintain accountability, oversight and strategic guidance for LHDs?
 - Service agreements within the NSW Health Performance Framework provide an adequate accountability mechanism between the Ministry of Health and LHDs.
 - The NSW Health Performance Framework allows for adequate monitoring of LHD performance by the Ministry of Health, the community, and other stakeholders.
 - Performance monitoring provides appropriate oversight, including intervention and coordination where necessary by the Ministry of Health to address poor performance and promote efficiency in service delivery.

Audit scope and focus

In assessing the criteria, we examined:

1. LHD board papers (including terms of references, recent agenda and minutes), including papers of selected board committees
2. LHD board member induction materials and role descriptions
3. documents relating to LHD board performance reviews
4. documents relating to NSW Health's 'tuning' review of governance
5. documents that support the negotiation of service agreements by LHDs and the Ministry, including briefing papers and meeting minutes
6. documents (including policy, guidelines or processes) that:
 - a) direct or guide the process of negotiating service agreements
 - b) direct or guide the preparation (by LHDs) of annual attestation statements against governance standards, and the management and use (by the Ministry of Health) of those attestation statements
7. documents that set out how LHD underperformance will be managed (by both the LHD and the Ministry)
8. documents regarding occasions where LHD underperformance has required Ministry intervention
9. LHD performance reports (both internal reports to the board or board committees, as well as external reports to the Ministry of Health)
10. documents (including policy, guidelines or processes) that set out how performance reports should be prepared, disclosed, monitored and actioned
11. data quality statements for reported LHD performance measures

12. documentation from other stakeholders obtained throughout the audit such as research and studies, statistical data and analysis
13. information from other jurisdictions for comparison.

This audit focused on the effectiveness and efficiency of high-level institutional governance arrangements that establish the responsibilities and functions of LHDs (including with reference to the Ministry of Health), rather than governance practices performed within LHDs.

However, practices within LHDs were relevant where they revealed something about the adequacy of the overall governance arrangements – this included where an activity was performed within an LHD in a way that is unnecessarily duplicative of efforts done in other LHDs, inherently inefficient (for example, due to lack of scale) or ineffective (for example, due to lack of a specialist skill or knowledge).

Audit exclusions

The audit did not examine the governance of NSW public health organisations other than LHDs, except to the extent that another public health organisations may be relevant to the governance of LHDs.

Audit approach

Our procedures were:

1. Interviews in five selected LHDs of (where available):
 - a) Chairs of LHD boards
 - b) Chief Executives
 - c) Audit and Risk Committee Chairs
 - d) Internal Audit Executives
 - e) Chairs of Community Engagement Committees
 - f) Chairs of Finance and Performance Committees
 - g) Senior executives with roles and functions related to the audit objective and scope.
2. Interviews with senior staff from the Ministry of Health, including:
 - a) in areas with responsibility for negotiating and monitoring service agreements and performance reporting
 - b) staff with responsibility for high-level governance roles
 - c) subject matter experts in health system management and governance, including contributors to the 'tuning governance' project and the NSW Health Governance Compendium.
3. Interviews were conducted with other senior stakeholders from:
 - a) Australian Salaried Medical Officers Federation
 - b) Gratton Institute
 - c) Health Consumers NSW
 - d) Medical Staff Council NSW Executive
 - e) NSW Agency for Clinical Innovation
 - f) NSW Bureau of Health Information
 - g) NSW Clinical Excellence Commission
 - h) Other state health departments.

4. We reviewed documentation relating to governance in the five LHDs and the Ministry, including:
 - a) governance-related frameworks, policies, legislation and by-laws
 - b) board and committee charters
 - c) board and committee papers and minutes
 - d) LHD performance reports and planning documents
5. We conducted an online survey of board members of all NSW LHDs, seeking their views on:
 - a) board functions (particularly around understanding and clarity of those functions)
 - b) board capability (including skill-mix, induction, and support)
 - c) board performance against a range of defined functions.

The audit approach was complemented by quality assurance processes within the Audit Office to ensure compliance with professional standards.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Audit Standard ASAE 3500 Performance Engagements and other professional standards. The standards require the audit team to comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance and draw a conclusion on the audit objective. Our processes have also been designed to comply with requirements specified in the *Public Finance and Audit Act 1983* and the *Local Government Act 1993*.

Acknowledgements

We gratefully acknowledge the co-operation and assistance provided by the many individuals who gave their time to be interviewed for this audit or participate in our online survey.

We particularly thank those people in LHDs who engaged openly and generously in this audit.

Audit cost

Including staff costs and overheads, the estimated cost of the audit is \$180,000.



Appendix seven – Performance auditing

What are performance audits?

Performance audits determine whether state or local government entities carry out their activities effectively, and do so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of an audited entity, or more than one entity. They can also consider particular issues which affect the whole public sector and/or the whole local government sector. They cannot question the merits of government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in section 38B of the *Public Finance and Audit Act 1983* for state government entities, and in section 421D of the *Local Government Act 1993* for local government entities.

Why do we conduct performance audits?

Performance audits provide independent assurance to the NSW Parliament and the public.

Through their recommendations, performance audits seek to improve the value for money the community receives from government services.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, state and local government entities, other interested stakeholders and Audit Office research.

How are performance audits selected?

When selecting and scoping topics, we aim to choose topics that reflect the interests of parliament in holding the government to account. Performance audits are selected at the discretion of the Auditor-General based on our own research, suggestions from the public, and consultation with parliamentarians, agency heads and key government stakeholders. Our three-year performance audit program is published on the website and is reviewed annually to ensure it continues to address significant issues of interest to parliament, aligns with government priorities, and reflects contemporary thinking on public sector management. Our program is sufficiently flexible to allow us to respond readily to any emerging issues.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team develops an understanding of the audit topic and responsible entities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the audited entity, program or activities are assessed. Criteria may be based on relevant legislation, internal policies and procedures, industry standards, best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork, the audit team meets with management representatives to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with management representatives to check that facts presented in the draft report are accurate and to seek input in developing practical recommendations on areas of improvement.

A final report is then provided to the head of the audited entity who is invited to formally respond to the report. The report presented to the NSW Parliament includes any response from the head of the audited entity. The relevant minister and the Treasurer are also provided with a copy of the final report. In performance audits that involve multiple entities, there may be responses from more than one audited entity or from a nominated coordinating entity.

Who checks to see if recommendations have been implemented?

After the report is presented to the NSW Parliament, it is usual for the entity's audit committee to monitor progress with the implementation of recommendations.

In addition, it is the practice of Parliament's Public Accounts Committee to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report received by the NSW Parliament. These reports are available on the NSW Parliament website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

The Public Accounts Committee appoints an independent reviewer to report on compliance with auditing practices and standards every four years. The reviewer's report is presented to the NSW Parliament and available on its website.

Periodic peer reviews by other Audit Offices test our activities against relevant standards and better practice.

Each audit is subject to internal review prior to its release.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 02 9275 7100.

OUR VISION

Our insights inform and challenge government to improve outcomes for citizens.

OUR PURPOSE

To help parliament hold government accountable for its use of public resources.

OUR VALUES

Purpose – we have an impact, are accountable, and work as a team.

People – we trust and respect others and have a balanced approach to work.

Professionalism – we are recognised for our independence and integrity and the value we deliver.

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