5. Board structure and renewal

Effective boards contain a diverse mix of directors who work cohesively, have a relevant and well balanced skill set and are supported by relevant committees. The structure, selection and composition of boards impacts the performance of individual directors and the collective board, making board appointments and the board evaluation process challenging but critical.

Questions that directors of health services should ask

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

Red flags

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

Introduction to the chapter

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

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

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

Governance and board structure

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

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

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

Board composition

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

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

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

It is critical that the board Chair advises DHHS and/or BMAC of any emerging skill or leadership gap to enable proactive management of that risk to the board's composition.

Board competencies, skills and expertise

Whilst the competencies required for a health service board may vary slightly depending on its strategy, service mix and operating environment (metropolitan, regional, rural), there are a core set of skills and competencies that all health service boards must have:[78]

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

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

See **Chapter 2**: Clinical Governance.

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

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

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

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

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

Board diversity

Diversity is an important element in effective and high-performing boards. The economic arguments for greater diversity on boards have been identified in various widely publicised studies.[79] Interestingly, these studies demonstrate a correlation between increased diversity at higher levels of the organisation and stronger organisational and financial performance.

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

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

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

In structuring the board to incorporate value from diversity, health services should consider the mix of skills, backgrounds, experience, expertise, age, gender and perspectives of directors that would be necessary to meet the unique requirements of the health service. Diversity is not always about physical, political or social attributes, it can also refer to diversity of thought, diversity of approach and diversity of ideas. The advantages of having a board that comprises different genders, ethnicities, political and social beliefs, are that each individual brings a different view to the decision-making process. An emphasis on director diversity can yield three key benefits[80]:

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

Benefits of diversity at board level

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

Benefits of diversity on boards:

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

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

[80] Institute for employment studies, *Diversity at senior team and board level* (2014), Report 504. Available from: http://www.employment-studies.co.uk/system/files/resources/files/mp95.pdf

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

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

Locals or outsiders?

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

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

The *Targeting Zero* Report specifically recommended more independent directors particularly for rural and regional boards.[81] This included that independent clinicians and external (i.e. non-locals) directors be appointed to boards to enable a more objective perspective on the board that is independent of local issues and reduce potential 'group think'.[82] External or non-local directors may also be the only way a board can obtain certain key skills (such as a clinician) – as such, the appointment should, where possible, assist the board in filling a major skills gap while also providing a view independent of local issues or community relationships.[83] This does not reduce the duties or obligations of that external director – including in relation to attendance.

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

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

Board appointments and tenure

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

[81] See pages 26-7 of the *Targeting Zero* report.

[82] See page 28 of the *Targeting Zero* report.

[83] Refer to Recommendation 2.1 of the *Targeting Zero* report.

Public hospital and MPS appointment process considerations

Should a director reach tenure, a process of appointment must take place in order to fill the vacancy and replace those skills. The board (along with DHHS) must publish a notice in a newspaper in the area where the hospital is situated inviting nominations for directorship of the board that advertises and seeks applications from potential candidates. A shortlist is created and candidates are then interviewed by a board panel (consisting of 3 or more directors).

To avoid any conflicts (perceived or otherwise) the board panel should not include the CEO or any board directors with expiring terms. If the board requires assistance in forming a panel (due to Chairperson expiry or availability of board members), the board should seek assistance from DHHS and/or their closest Regional Public Health Service. Candidates are then nominated and recommended (by the board in collaboration with DHHS and BMAC) to the Minister in accordance with the Enabling Acts.

Public health service, VIFMH and AV appointment process considerations

Appointments to the board must be made through nomination by the chair, DHHS and ultimately the Minister. For public hospitals, where a board is already in place, DHHS must publish a notice in a newspaper in the area where the health service is situated inviting nominations for directorship of the board. For all health services, the chair will make recommendations to DHHS with respect to reappointments and other potential candidates. The names of candidates identified by DHHS, in collaboration with the board chair (in order of preference), are then submitted to BMAC and the Minister for consideration. In practice this requires the board, DHHS and BMAC to fully understand the skills lacking and/or required (both technical and behavioural) on the board, in order to meet the Minister's policy priorities, the obligations of the Enabling Acts and the objectives of the board.

Tenure and appointment considerations

Managing tenure and succession of directors is a particularly important consideration, particularly in regional and rural areas where there is a smaller pool of candidates available to take on board roles.

When making reappointments after periods of long tenure, the following should be considered:

- directors with tenure of 9 years will not be recommended for reappointment
- carefully balance experience and knowledge of the health service associated with long tenure against a fresh new perspective that a new director can bring (often directors with long tenure benefit from a break from director duties, or refresher training to ensure that they are up to date and current with emerging issues and better practice)
- independence is an important attribute of a director, and long tenure can indirectly impact on a director's ability to remain independent
- familiarity and personal relationships between board directors and management built over long periods of tenure can blur the lines of responsibility and accountability, and therefore new board directors should be considered to ensure greater separation of governance from operations

Ministerial approval of an exemption from the maximum tenure limit is rare and requires substantial rationale and evidence to meet the high requirement. It will also usually require a commitment to manage the issue that the exemption seeks to temporarily address. For example, if the exemption is to manage a skill gap, the health service will then be expected to specifically seek out and recruit a candidate with those skills. Additionally, even if an exception is approved, only a 1 year term will likely be given.

The HLA Bill brings the tenure limitation into law for all health service boards. It also enables the Minister to make exemptions to tenure (rather than the exemption having to be sought from GiC).

Board appointments

Attracting board candidates

In advance of the annual appointment round, health services should be speaking with potential board candidates and alerting them to any upcoming vacancies on the board.

Health services should be proactive in attracting candidates to the board. Health services have historically held information sessions, hospital tours and other local events to attract suitable candidates.

While GiC officially appoints the director, the board should take an active role in the attraction and identification of director candidates for their health service.

The appointment process

The Enabling Acts (such as the HSA) outline the process for appointment of directors to the respective boards. Refer to **Appendix 2** for section references.

Each Enabling Act specifies the minimum and maximum number of directors that each health service must have. A board is not required to have all positions filled, particularly if all skills are covered. Appointments are made by the GiC on the Minister's recommendation. Ministerial recommendations are made with the support of the BMAC (discussed further below).

The GiC (on the Minister's recommendation through Cabinet) has the power to appoint one of the directors to be the board chair.

The Enabling Acts provide for directors to be appointed for terms of up to 3 years, and for them to be reappointed. Board directors cannot hold board positions for longer than 9 consecutive years.

Figure 5-1 Board appointment and renewal processes (Source: Victorian Government)

Finding people to fill board positions can be difficult, especially in regional and rural areas. A brochure is updated annually and made available to boards to assist public hospital and MPS boards in particular with their recruitment activities.

All boards need to be proactive when it comes to attracting and retaining directors – including giving thought to successional planning.

As vacancies arise, boards should actively engage with the community to help build awareness and interest amongst potential candidates. Activities could include:

- placing advertisements in local and regional papers
- advertising vacancies within the hospital
- updating the health service webpage with useful information for potential candidates
- holding information sessions at the health services for interested candidates to come along and meet the board, understand the role and ask questions
- hold tours of the health service
- engage with professional employers with the necessary skills e.g. the regional health service, the local law firm, etc.

Director due diligence

The role of the health service director has become increasingly onerous with directors bearing increased responsibility and accountability. It is therefore critical for prospective directors to undertake their own due diligence on the health services they are invited to join. This is to ensure they can make a useful contribution and effectively discharge their duties.

Prior to accepting a board appointment, an individual should:

- investigate the particular health service and the services it provides
- gather information about the people in leadership roles and arrange to speak with key directors and senior management
- review documentation supplied by the health service, such as organisational policies, risks and strategies
- be satisfied that they are equipped with the requisite skills and knowledge to properly discharge their responsibilities as a director.

Position description

To support activities in attracting new directors, a position description is available to candidates in order for them to self-assess their skills and competencies. An example of a position description is provided in **Appendix 5**: Director Position Description

Skills definitions associated with the position description

Skills definitions are detailed in the position description. These definitions provide guidance on the sort of skills, qualifications and/or experience required in order to satisfy the criteria.

The definitions include a basic minimum standard as well as providing guidance on what a more highly skilled candidate would possess. Further, the definitions indicate the types of responsibilities the candidate might be required to undertake should they be selected as a director of a board.

For example, in order to satisfy the law definition, candidates must show, at the very least, they have obtained a law degree. As stated above, definitions can change from year to year.

What candidates should expect when applying

When applying for a director role on a public health board, candidates are required to fill in a number of forms supporting their application. This includes a standard application form that requires the following

information:

- contact details
- professional experience - through a resume or curriculum vitae (CV)
- consent to probity checks that will be conducted by DHHS including police checks, insolvency checks and the disqualified director check which will identify any prior breaches of the *Corporations Act 2001* (Cth)
- providing DHHS with a DPI to identify any actual, potential or perceived conflicts.

Applications are lodged via the Victorian Government's online board e-Recruitment tool available at www.getonboard.vic.gov.au

Candidates will also be expected to fill in a police check document should their application be progressed. This will include the requirement for an international police check if the candidate has lived for 12 months or more outside of Australia in the last ten years.

Boards Ministerial Advisory Committee (BMAC)

BMAC was established in response to the recommendations from the *Targeting Zero* report.

Initially, BMAC will consist of four members with each member chosen to represent a specific area of expertise that will facilitate identification of skills gaps on the relevant boards, and allow an effective assessment of the qualifications and experience of potential board appointees.

BMAC's key objectives

The key objectives are to:

- provide advice to the Minister on proposed board appointments to health services
- ensure all boards are highly skilled, independent and objective.

BMAC will also provide advice on proposed board appointments for HPV, AV, and Forensicare to the Minister, the Minister for Ambulance Services, and the Minister for Mental Health, respectively.

Functions of BMAC

The proposed functions of BMAC are:

- to provide advice to the Minister on how to ensure all health service boards are highly skilled, independent and effective
- responsibility for overseeing the board appointments process, in accordance with the legislative requirements set out in the Enabling Acts and other relevant Victorian Government policies
- develop clear guidelines covering the skill mix and experience required for health service boards (the skills matrix)
- set expectations for ongoing professional development of board directors
- work closely with health service boards to identify any skill gaps, and advise on how identified skill gaps are best addressed
- work closely with DHHS in determining when delegates should be appointed to health service boards if skills gaps cannot be filled
- consider staggering of board appointments to smooth the appointment process workload.

BMAC will also provide the Minister (and other relevant Ministers) as required, with advice on other matters relating to further improvements to the board appointments process, or matters more generally impacting the effective operation of BMAC.

Board effectiveness and evaluation

Effective boards are the cornerstone of Victoria's governance model. This includes:

- development of comprehensive induction packages for new board directors
- facilitating ongoing training and education opportunities for board directors
- evaluation of board performance on an annual basis.

DHHS has developed a framework to support board effectiveness, the Building Board Capability Framework. This informs boards of current best practice to achieve board effectiveness and the means by which DHHS will work to support boards to achieve this.

The framework and board assessment tools are available at www.health.vic.gov.au/governance

Induction and education

Directors typically bring a wealth of experience to their boards, based on knowledge and skills generated over their careers. Nevertheless, health service boards should develop a comprehensive induction package for new directors, as well as formally assessing, encouraging and financing the ongoing training and education needs of directors and the board as a whole.

While DHHS provides induction training annually for all new health service directors, this should not be relied upon in isolation. Each health service is different with its own challenges and service mix. Induction provided by DHHS is broad to account for all services and does not cover board specific matters such as etiquette, conduct, meeting frequency and other procedural aspects that are matters for the board.

Induction

Board director induction programs should be designed to make the most out of a director's existing knowledge base by filling any knowledge gaps, typically concerning the health sector landscape and any health service specific issues. Induction programs make it more likely that new directors can make an immediate contribution.

Board director induction programs should be tailored to take into account the appointee's knowledge and experience, and will vary depending on health service structure, processes and the major issues it faces.

Typically, a combination of written materials, coupled with presentations and activities, such as meetings and site visits, will provide the new director with a realistic picture of the health service's position and the challenges it faces. It will also serve to foster a constructive relationship between the new director, their fellow directors and senior management.

The chair should take a leading role in ensuring the delivery of a tailored and properly balanced induction program. Initially, a new director should receive an induction pack, which may include the following information:

- **health service information** – strategic plans, the SoP, financial accounts, regulatory frameworks, corporate communications, health sector information, risk profile and appetite, and health service history
- **governance framework** – board charter/governance statement, annual agenda, selected board packs, full details of directors, committee structures, board processes, assurance providers, resources available, key stakeholders, procedures for sign-off of financial statements and items requiring approval outside of board meetings
- **management information** – names and background of senior management, organisational and management structure outline

- **director's code of conduct** – roles and responsibilities of both individual board directors and the board as a whole, including behavioural expectations and boardroom conduct for all board directors. This includes codes established by the VPSC (e.g. *Director's Code of Conduct*) as well as any codes developed specifically by the health service, tailored to its own context and culture.

In addition to the provision of induction materials, it is also important to schedule in-depth meetings for the new directors to discuss the board's charter, how the health service operates, the main issues facing the health service, the financial position, strategic objectives and other matters of significance.

An induction to board committees, with particular emphasis on those board committees which the new director will join, should not be overlooked. An induction pack containing relevant documents such as committee charters, annual agendas, copies of minutes, plus a full briefing by the relevant committee chair will help the new director gain an appreciation of the major issues.

The VPSC provides a checklist of the sorts of information to be provided to new board directors.[84]

Ongoing education

Through the board evaluation process, areas will be identified where further education may enhance board and individual director effectiveness. The board should ensure resources are budgeted to provide appropriate educational opportunities for directors. The chair should address the developmental needs of the board as a whole, plus those of individual directors. The CEO and management may play a role in facilitating the process.

Training and other resources are available from DHHS, VMIA and other health peak bodies, such as the VMIA, however, it is important that the board manages its own education needs and does not simply passively wait for someone else to provide it.

The development of a Professional Development Calendar can be a useful tool to assist directors in identifying and planning education and training opportunities, which are offered from a range of service providers. An example Professional Development Calendar is provided in **Appendix 6**.

There are also various online resources that can assist directors, for example, membership of organisations like the Australian Institute of Company Directors.

Board assessment and evaluation

Boards should formally evaluate their performance annually to achieve best practice governance with the chair responsible for ensuring it is conducted in a constructive and effective manner. The chair should informally evaluate the board more regularly.

Among other things, the annual performance assessment process should identify skill gaps and training needs, and be used to formulate a program of board education activities for the coming year. In the same way that health services develop staff for their roles, board director development is vital to the effective functioning of the board.

It is essential the board has a formal and rigorous process for regularly reviewing the performance of the board, its committees and individual directors, and addressing any issues that may emerge from that review.

More information on board assessment and evaluation is in ***Chapter 8****. Productive Meetings*.

[84] Available here https://vpsc.vic.gov.au/governance/board-directors/director-welcome-and-induction/

Board evaluation tools

A *Skills and Competencies Matrix Capability Assessment* (refer to **Appendix 6**) is a key tool that assists DHHS and health service boards in setting out the mix of capability and diversity that the board currently has or is looking to achieve in its directorship. This is also a useful tool for succession planning and helping identify gaps in the collective skills of the board. This tool should be utilised on an annual basis as part of a broader plan for evaluating the balance of skills, knowledge, experience, independence and diversity on the board. The rationale for this approach is that such an evaluation will enable the identification of specific skills that will best increase board effectiveness.

In addition to a competency assessment, an analysis of director behavioural types may help the board function as an effective decision-making body. When selecting future directors and planning director education, a tailored competency and behavioural-based analysis may assist the board to identify gaps and focus on recruiting individuals with the required competencies.[85]

Board succession planning

Board succession planning challenges boards to anticipate and plan for their future needs. It should be a continuous process that is regularly considered by the board so that changes in the board composition can be anticipated and planned for in advance.

Board succession planning is built on:

- an assessment of the challenges and opportunities facing the health service, now and in the future
- an analysis of the core skills, competencies and behaviours that are required, both immediately and in the future, for both the board and its committees
- an honest evaluation of the skills, competencies and behaviours of existing directors, including their strengths and weaknesses, skills and experience gaps, current age range and gender composition, and length of tenure
- assessments of existing directors' performance.

In developing a succession plan, the chair's role needs to be considered. In instances where the current chair's retirement or tenure date is known, plans should be set to identify a new chair, either internally or externally.

Boards should also have a contingency plan for the chair's role, and a formal deputy chair, in the case of an unexpected event.

Considerations for board evaluations

1. **Independent evaluator**

While an independent party is not required every year, it is recommended that the board have an independent performance assessment every 2 (or at the longest) 3 years.

2. Each director should assess and score each other director

This enables performance and behavioural issues to be raised to the board chair's attention (including the chair's own performance and conduct). This is particularly helpful for the chair to manage the performance of each director as the assessment is the view of the board, not just the chair or a single complainant.

Consideration should be given to whether each director's performance is made known to the rest of the board. A useful strategy is to advise the board of the range of scores for that indicator so that the individual director can understand their performance within the context of the range of their immediate peers.

3. **Assess attendance** (including tardiness)

This measure, while a little absolute, can indicate the level of commitment a board director is either willing or able to commit to the board.

[85] Refer also to: https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/education-resources-for-boards/board-assessment

Succession planning

Continuity of directors is an important factor in boards as it is useful for ongoing knowledge and understanding to be brought to the boardroom. However, it is equally important to have diversity on boards to provide new perspectives, a fresh approach and challenge to possibly well-entrenched board practices. Diversity in age, gender, background, skills and tenure are all equally important.

Recognising there are benefits to having a diverse board means that boards are constantly reviewing the needs of the health service and the ability of individual director's skills and experience to meet these needs. Succession planning plays an important role in ensuring the required skills are known and that a pool of potential candidates is identified. Succession planning can also involve training of existing board member to ensure that their skills remain relevant to the health service's current and future needs, so that when a directors' tenure is reached the board has a range of candidates for the Minister to recommend for appointment.

Astute directors will recognise that it may be time to leave the board, if their skills and experience do not align with the strategic objectives of the health service, and may not seek reappointment in the best interests of the health service. Additionally, directors can fulfil alternative formal and informal roles including acting as a mentor, acting on a different board, ambassadorships, and fundraising and volunteering.

Resignation and removal of directors

Each Enabling Act also provides for the resignation and removal of directors. A director is able to resign by writing a formal letter to GiC. The resignation needs to be formally accepted by GiC in order to be effective. In practice, the letter is addressed to the Minister and submitted to DHHS, which arranges for the letter to be delivered to GiC on behalf of the Minister.

An original letter, signed and dated by the resigning director, is required by GiC to effect the resignation. Only then can the Minister recommend to GiC that the director be released of his/her liabilities and the appointment ceased.

Resigning directors must be aware that their legal duties and responsibilities continue until the effective date of the resignation, which is only when that resignation is formally accepted by GiC.

GiC (on the recommendation of the Minister) has the power to remove a director or all directors of a board. The Minister must recommend the removal of a director if the director:

- is physically or mentally incapacitated
- has been convicted of a serious offence
- has been absent without leave from all board meetings over a six-month period
- becomes an undischarged bankrupt.

Leaves of absence

The Enabling Acts allow the board to authorise leave (e.g. missing one meeting due to illness or a holiday) and acting arrangements as part of their own internal procedures, however, any significant leave of absence (where the person cannot take part in critical decisions, such as where the director is engaged in a legal proceeding or investigation) requires additional steps.

A leave of absence can be requested by a director and must be approved by the board and DHHS. Any leave of absence must be approved and is, as for resignations, not effective until formally accepted by the Government. When approving leaves of absence, the board and DHHS should consider the size of the board and its capacity to meet quorum or effectively make decisions with a board director absent for a period of time.

Where the leave of absence involves a chairperson who was appointed by GiC as the chairperson (such

as the chairperson of a public health service, VIFMH or AV) the board will need to seek consent from the Minister for both the leave of absence and the acting chairperson. This ensures that the Minister responsible for the Enabling Act has authorised the acting chairperson's authority.

Note **a leave of absence cannot exceed six months** without special permission. A director can seek special permission from the Minister for a leave of absence greater than six months, but this must be sought well in advance as the leave may require the approval of GiC.

Board committees

Board committees provide an additional way for a board to effectively structure their workloads through the delegation of more comprehensive examination of key strategic or risk issues. Committees carry out a thorough analysis of important matters and make recommendations for the board to consider.

The board remains accountable for all decisions.

Under the HSA (as an example), boards are required to establish three committees: finance, audit and quality committees. This requirement was expanded to public hospitals and MPS under the HLA Bill.

The Standing Directions of the FMA[86] also requires all health services establish an audit committee to oversee and advise the board and CEO on matters of accountability and internal control affecting the operations of the health service. The primary role of an audit committee is to consider reports from officers of the entity and the auditors that provide assurance about the integrity of the entity's financial processes, systems and reporting.

Please note that the board chair should not be the chair of the audit committee. For more information on audit committee structure and requirements, refer to **Chapter 4**: Statutory Duties.

The Government's executive remuneration policy also requires all boards to establish a remuneration committee with at least three directors. The role of a remuneration committee is to determine the health service's policy and practice for executive remuneration, and the individual remuneration packages for its executives.

It is common practice for large health services to have additional committees such as an education and research committee. Committees may be standing committees or established for a specific purpose. Carver (1997, pp. 145–147) and many other governance experts favour a minimalist approach to committees, counselling they should be established to aid the process of governance, not management.

The VPSC advises that committees should be established with:

- a specific charter, with clear terms of reference
- delegations that do not undermine the board's delegations to the CEO
- an appropriate number of directors
- procedures for agendas, minutes and reporting to the board
- a clear expectation that the decision-making responsibilities of the board are not to be compromised by the activities of any committee, and that significant issues will be reported to the board for discussion and decision-making.[87]

[86] Available from: http://www.dtf.vic.gov.au/Publications/Government-Financial-Management-publications/Standing-Directions-of-the-Minister-for-Finance-2016/Standing-Directions-2016-publications

[87] http://vpsc.vic.gov.au/governance/board-operations/committees-and-delegations/.

Advisory committees

The HSA requires the boards of directors of metropolitan and major regional health services to appoint a primary care and population health advisory committee, and a community advisory committee. It also specifies that boards may appoint other advisory committees if they choose.

With respect to community advisory committees, boards:

- are able to decide the number of directors
- must ensure the directors are people able to represent the views of the communities served by the health service
- must give preference to people who are not registered health practitioners within the meaning of the *Health Practitioner Regulation National Law Act 2009* (Vic) and who are not currently, or recently, involved in providing health services
- must fill a vacancy within three months of it arising.

With respect to primary care and population health advisory committees, boards:

- are able to decide the number of directors
- must ensure the directors have between them:
- expertise in, or knowledge of, the provision of primary health services in the areas served by the health service
- expertise in identifying health issues affecting the population serviced by the health service and designing strategies to improve the health of that population
- knowledge of the healthcare services provided by local Government in the areas served by the health service
- must fill a vacancy within three months of it arising.

The HSA permits the Secretary to publish guidelines relating to the composition, role, functions and procedure of advisory committees. Subject to any guidelines, the HSA states the procedure of an advisory committee is in its discretion. Guidelines have been established for community advisory committees but not for primary care and population health advisory committees.

The guidelines define the role of the community advisory committee as follows:

- to provide direction and leadership in relation to the integration of consumer, carer and community views into all levels of health service operations, planning and policy development
- to advocate to the board on behalf of the community, consumers and carers.

Managing non-performance

The Enabling Acts set out the role of the board. Boards are responsible to the Minister for the effective and efficient governance of their health service, including the requirements, mechanisms and processes surrounding board appointments, function and objectives.

The HSA sets out several options available to the Minister for managing non-performance should some or the entire board be unable to adequately fulfil its obligations under the HSA. This includes, but is not limited to:

- removal and resignation of directors (the board can also seek approval for the removal of a director or directors)
- appointment of one or more delegates
- appointment of an administrator
- other sanctions (e.g. censure, instructions that a health service is required to follow).

Performance management of individual directors (regarding performance or behaviours) is primarily a matter for the board chair. This is discussed in more detail in **Chapter 11**: Organisational culture and leadership.

Removal of directors

The GiC, on recommendation of the Minister, may remove a director from a health service board. Common reasons for director removal relate to non-performance and failure to meet their obligations under the relevant Enabling Act, failure to act in accordance with the law and inappropriate behaviours. The Minister must provide written notice to the director (and the board).

For 'public health services', s65V of the HSA outlines more specific criteria wherein the Minister must recommend the removal of a director if they:

- are physically or mentally unable to fulfil the role of a director of a board
- have been convicted or found guilty of an offence, the commission of which, in the opinion of the Minister, makes the director unsuitable to be a director of a board
- have been absent, without leave of the board, from all meetings of the board held during a 6-9 month period.

Specific details of the relevant sections of the Enabling Acts relating to removal of directors is outlined in **Appendix 2**.

Appointment of a delegate

The Enabling Acts permit the Minister to appoint up to two delegates to a board to attend meetings and provide advice and information to assist the board in their understanding of their obligations under the HSA if they believe a delegate appointment will assist with improving the health service's performance.

A delegate is not a member of the board and thus cannot vote. However, the board and CEO are required to provide full access to board meetings, minutes and other reasonable information requests as if the delegate were a director of the board.

The relevant sections of the Enabling Acts relating to appointment of board delegates are outlined in **Appendix 2**.

The role of the delegate is to observe how the board operates and provide guidance and advice to the board, with the intention of providing feedback to the Minister regarding the board's abilities to fulfil its duties under the Enabling Act. Specifically, the delegate is required to:

- attend meetings of the board and observe its decision-making processes
- provide advice or information to the board to assist it in understanding its obligations under the relevant Enabling Act
- advise the Minister and the Secretary on any matter relating to the health service or the board.

It is therefore important the delegate is skilled in governance and the requirements of the Enabling Acts, such that recommendations or improvements can be made to assist the board to improve the performance of the health service.

The HLA Bill expands the circumstances for which the Minister can appoint a delegate, including where it might assist in the establishment of a new health service (i.e. to assist a new board) and to improve quality and safety of the health service.

The Minister can appoint up to two delegates to the board for a period of up to 12 months, irrespective of whether the board has requested it. The appointment of a delegate must be published in the Government Gazette, with details of the term of appointment and any remuneration. Delegates must

not be a board director of a health service and can apply for reappointment when they reach the end of their term. The Minister may also revoke the appointment of a delegate.

Obligations of the board to the delegate

The board must allow a delegate to attend any meeting of the board and provide them with all relevant information or notices provided to other directors during their appointment. In other words, delegates are to be treated as an ordinary board director for all board processes. The delegate may be required to vote and the board must allow them to participate in the voting process.

Appointment of administrator

The GiC, on the recommendation of the Minister, may appoint an administrator to exercise all the powers of the board. The administrator is subject to all the duties of the board. On the appointment of an administrator, the directors of the board cease to hold office. The appointment of the administrator can be revoked, with 28 days public notice. Revocation will be followed by election and appointment of a new board in accordance with the relevant requirements.

The Enabling Acts permit the Minister to recommend the appointment of an administrator, and/or that the health service be closed, if the Minister is satisfied that (not exhaustive):

- the service is inefficient or incompetently managed
- the service is failing to carry out its functions, or failing to carry them out effectively
- the service has negligently failed to comply with an agreement entered into under the relevant Enabling Act

The HSA Bill expands the grounds for the Minister to appoint an administrator to include circumstances where the health service has:

- has failed to provide safe, patient-centred and appropriate health services; or
- has failed to foster continuous improvement in the quality and safety of the care and health services it provides.

The GiC must endorse this process.

In the event the Minister proposes the appointment of an administrator, the Minister must give written notice to the health service and consider any submissions made by the service within seven days of the notice. All directors of the board cease to hold office upon the appointment of an administrator.

The relevant sections of the Enabling Acts relating to appointment of an administrator are outlined in **Appendix 2**

Amalgamation

The GiC, on recommendation of the Minister after receiving advice from the Secretary, may direct two or more registered health services to amalgamate. Any direction to amalgamate must be made by Order and published in the Government Gazette. In this instance, the two entities directed to amalgamate will cease to exist and be wound up. A new entity and a new board will then be established under the relevant Enabling Act.

An amalgamation may be ordered if the Secretary is satisfied that the health services can be more effectively delivered under a new structure. Before the recommendation can be made to the Minister and GiC, a report must be prepared that outlines the rationale and proposed structure to take the health services forward. For example, s64 of the HSA outlines the process and administrative requirements that must be adopted before an amalgamation can take place. Given the extent of consultation that must occur before this decision can be made, this option is one that requires strong rationale, but one that ultimately supports the effective achievement of the objectives of the Enabling

Acts.

Significantly, no Victorian health service has been forced to amalgamate. All amalgamations of health services have been voluntary and reflect both the other powers available to the Minister (such as an administrator or delegate appointment) and what is best for those two (or more) agencies determined by those agencies. The HSA Bill also amends the HSA to enable MPS to engage in voluntary amalgamations.

The relevant sections of the Enabling Acts relating to board amalgamations are outlined in **Appendix 2.**

Useful references

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Papers/4_Board-Assessment.pdf [Note: site registration at www.nadler-leadership-advisory.com may be required to access white papers].

- HSA Bill 2nd reading speech can be accessed from Hansard at legislation.vic.gov.au
- Clinical Governance Framework at **Chapter 2**.