Department of Health and Human Services

The Director’s Toolkit

A resource for Victorian health service boards

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# Acronyms and definitions

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

| Acronym | Full description |
| --- | --- |
| AACC | Aged Care Complaints Commissioner |
| AAQHC | Australasian Association for Quality in Health Care |
| AAS | Australian Accounting Standards and Interpretations |
| AASB | Australian Accounting Standards Board |
| ABF | Activity based funding |
| ACAS | Aged Care Assessment Services |
| AGM | Annual General Meeting |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AMA | Australian Medical Association |
| ASA | *Ambulance Services Act 1986* (Vic) |
| ASIC | Australian Securities and Investments Commission |
| AV | Ambulance Victoria |
| BBCAC | Building Board Capability Advisory Committee |
| BCV | Better Care Victoria |
| BMAC | Boards Ministerial Advisory Committee |
| CBC | Council of Board Chairs |
| CEO | Chief Executive Officer |
| CFO | Chief Finance Officer |
| COO | Chief Operations Officer |
| DHHS | Department of Health and Human Services |
| DMS | Director of Medical Services |
| DPC | Department of Premier and Cabinet |
| DPI | Declaration of Private Interests |
| DRG | Diagnosis Related Groups |
| DSM-V | Diagnostic and Statistical Manual of Mental Disorders, 5th revision. This the manual used primarily in the USA (but also widely used in Australia in addition to the ICD-10) for classification of mental disorders. |
| DTF | Department of Treasury and Finance |
| FMA | *Financial Management Act 1994* (Vic) |
| GiC | Governor in Council |
| HCC | Health Complaints Commissioner |
| HEER | Health Executive Employment and Remuneration Policy |
| HMI | Hospital Mortality Indicator |
| HPV | Health Purchasing Victoria, trading as HealthShare Victoria |
| HSA | *Health Services Act 1988* (Vic) |
| HSMR | Hospital Standardised Mortality Ratios |
| IBAC | IndependentBroad-based and Anti-Corruption Commission |
| IHPA | Independent Hospital Pricing Authority |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems, 10th Revision. This is the disease classification used in Australia cf. DSM-V  Notes:   * a CM suffix refers to Clinical Modification * an AM suffix refers to Australian Modification * a different number instead of 10 will refer to a different revision e.g. 9th revision |
| KPI | Key performance indicator |
| LHN | Local hospital network |
| LOS | Length of Stay |
| LTI | Lost Time Injury |
| MHA | *Mental Health Act 2014* (Vic) |
| MHCC | Mental Health Complaints Commissioner |
| MPS | Multi Purpose Service |
| NAESG | Non Admitted Emergency Services Grant |
| NDIS | National Disability Insurance Scheme |
| NEP | National Efficient Price (as determined by IHPA) |
| NSQHS Standards | National Safety and Quality Health Service Standards |
| NWAU | National Weighted Activity Unit against which NEP is paid (national equivalent of WIES) |
| OH&S | Occupational Health and Safety |
| OHSA | *Occupational Health and Safety Act 2004* (Vic) |
| OVA | Occupational Violence and Aggression |
| PAA | *Public Administration Act 2004* (Vic) |
| PDA | *Protected Disclosures Act 2012* (Vic) |
| PFG | Policy and Funding Guidelines (updated every year) |
| PMF | Performance Monitoring Framework |
| PRISM | Program Report for Integrated Service Monitoring |
| PSRACS | Public Sector Residential Aged Care Services |
| SCV | Safer Care Victoria |
| SoP | Statement of Priorities |
| SRHS | Small Rural Health Services |
| TRP | Total remuneration package (for an executive salary) |
| VAGO | Victorian Auditor General’s Office |
| VAHI | Victorian Agency for Health Information |
| VCC | Victorian Clinical Council |
| VGRMF | Victorian Government Risk Management Framework |
| VHA | Victorian Healthcare Association |
| VIFMH | Victorian Institute of Forensic Mental Health, also known as ‘Forensicare’ |
| VMIA | Victorian Managed Insurance Authority |
| VMO | Visiting Medical Officer |
| VPSC | Victorian Public Sector Commission |
| WIES | Weighted Inlier Equivalent Separation |

# Key definitions used in this Toolkit

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| --- | --- |
| Definition | Full description |
| Consumers | ‘patients’ and ‘consumers’ are terms often used to describe users of health services. In this Toolkit, ‘consumers’ has been used, unless it is part of a publication title or a quotation, as patients are not the only users of health services. |
| Directors | In this Toolkit, all board directors are referred to as directors or chairs as applicable, and the roles and responsibilities are outlined as applying to all boards. This includes members of the board of Health Purchasing Victoria, (trading as HealthShare). |
| Enabling Acts[[1]](#footnote-1) | *Health Services Act 1988* (Vic) (**HSA**), *Mental Health Act 2014* (Vic) (**MHA**), *Ambulance Services Act 1986* (Vic) (**ASA**)(in some circumstances other acts may also be applicable).  If one Enabling Act is referenced such as the HSA, the reader should presume the other Enabling Acts may also apply and should check the other Enabling Acts for clarification. |
| HLA Bill | Health Legislation Amendment (Quality and Safety) Bill 2017 was introduced into Parliament in June 2017 in response to the *Targeting Zero* report and the Government’s response, Better, Safer Care. This Bill amends the Enabling Acts for health services, in particular relating to obligations for board directors and the composition and conditions of appointment of boards. |
| HPV | Health Purchasing Victoria (HPV) is the organisation established to assist the Victorian health sector ease cost pressures through collective, strategic purchasing for all health services. |
| Minister | In this Toolkit, Minister refers to the Victorian Ministers for Health, Ambulance Services, and Mental Health where applicable. |
| Patient Experience Survey | Collects data from consumers of health services in Victoria and is used as a key feedback mechanism in clinical governance to identify areas for improved provision of service or management of risks. It is a critical stakeholder engagement and performance management / monitoring tool. |
| People Matter Survey | Regular survey of health service staff undertaken by health services to identify workforce engagement, participation, concerns or other feedback. It is a critical stakeholder engagement and performance management / monitoring tool. |
| Health services | The term ‘health services’ is used to refer to both the ‘public hospitals’, ‘public health services’ and multi-purpose services listed in the HSA, as well as Ambulance Victoria (ASA) and VIFMH (MHA) unless otherwise specified. |
| Secretary | The Secretary of the DHHS. |
| Victorian Clinical Council | Victorian Clinical Council is a council of clinicians and consumers whose purpose is to provide leadership and direction to make the health system safer and provide better care to all Victorians. |

# The CEO

Board and management play two distinct but equally important roles – the board sets the vision and strategy and the CEO handles implementation and operation.

As the group responsible for the appointment, performance management and removal of the CEO, the board must be clear on the difference between the two roles and select candidates accordingly. The CEO is the link between the board’s strategy and its implementation having responsibility for the day-to-day operations of the organisation.

## Questions that directors of health services should ask

* Does the board have confidence in the CEO and the senior management team?
* Does the CEO understand the role (including the obligations and monitoring requirements) of the board?
* Does the CEO, through attitude and behaviour, reinforce the appropriate ‘tone at the top’ for all employees of the health service?
* Does the board have a robust CEO selection process in place that aligns with the relevant Enabling Act and the HEER Policy?
* Prior to the appointment of a new CEO, do we (through the chair or selection panel) conduct rigorous reference checks?
* Is the CEO’s view regarding senior management and other talented people with strong leadership qualities considered?
* Have we developed a CEO and senior management succession and contingency plan that is periodically reviewed?
* Do the CEO’s responsibilities include attracting, developing and retaining high performers in the organisation and does the CEO encourage these activities?
* Are concerns about the CEO’s performance discussed with the CEO and appropriately documented?
* Does the board have a transparent process for determining management and executive remuneration?
* Has the board obtained Secretary approval prior to a CEO appointment or reappointment?
* Does our CEO take our concerns and/or directions seriously?

## Red flags

* The CEO selection process is conducted largely in-house within a pool of board directors’ friends and business associates.
* The CEO has been in the role for more than ten years without the market being tested.
* The board simply ‘ticks the box’ for CEO recommendations.
* Support and confidence in the CEO is divided amongst board directors.
* The CEO does not have KPIs or they are often not being met.
* CEO performance appraisal is conducted infrequently and informally.
* No contingency plan or succession plan exists for the current leadership structure.
* The CEO treats the board as an obstacle or burden, rather than with appropriate respect and due diligence.
* There is no senior executive development plan in place.
* There is no regular review or external assessment of senior executive talent.
* The board has restricted or no access to senior management.
* The CEO is regularly at entire board meetings (i.e. there are no in-camera sessions).

## Introduction to the chapter

This chapter considers the following:

* the relationship between the CEO and the board, and the separation between governance and operations
* how to set the board and the CEO up for success
* CEO succession and contingency planning.

## CEO and executive management

The CEO wields considerable delegated authority, reinforces the ‘tone’ of the health service and represents the organisation to external parties.

It is usual practice for a CEO to establish an executive management team (or similar) to:

* support the CEO
* exchange information and ideas
* provide input on the organisation’s direction
* influence the organisation at all levels.

Building a strong executive management team is essential for organisational success, especially at the more complex health services.[[2]](#footnote-2)

Factors associated with strong organisational leadership include:

* respective board and management roles and responsibilities are clearly delineated and articulated in writing
* board protocols covering directors’ access to executive managers outside of board meetings
* a CEO that provides appropriate direction, mentoring, support and guidance to executive management
* executive management who are empowered to share leadership responsibilities
* executive management who are rewarded for organisational, unit and individual performance, based on behavioural standards displayed and value creation outcomes
* management succession and development plans that cover all key positions, based on competencies, behaviours and experience to achieve the strategic vision
* full disclosure of conflicts of interest.

“Leaders establish the vision for the future and set the strategy for getting there; they cause change. They motivate and inspire others to go in the right direction and they, along with everyone else, sacrifice to get there”.

Dr John Kotter, Konosuke Matsushita Professor of Leadership, Emeritus (Harvard Business School)

## Role of the CEO

It goes without saying that, as a health service’s most senior officer, the CEO is critical to the performance of the service. The scope of activities and responsibilities assigned to the CEO are broad and far-reaching. Through their attitudes and behaviours, CEOs are instrumental in reinforcing the ‘tone’ of the organisation.

An effective CEO of a Victorian public health service:

* passionately leads and develops people
* is wise, courageous and makes the tough decisions
* always acts with integrity
* drives strategic vision and innovation
* is resilient in the face of setbacks
* successfully adapts to the health service’s ever‑changing circumstances
* demonstrates high-level commercial acumen
* meets immediate performance targets without neglecting longer-term growth opportunities
* provides visible leadership and commitment to the provision of safe, quality healthcare
* actively supports and demonstrates the expected conduct and culture of the service as set by the board.

### Delegated authority, not accountability

In putting its relationship with the CEO on a sound footing, a board needs to formulate a CEO’s job description and define the criteria for the CEO’s performance (usually led by the chair). There should also be a formal statement delineating the boundaries between board and management responsibilities, including the board’s retained authorities and those delegated to management (which is usually set out in the board charter/by-laws). A high-performing board will invest time and effort in constructing a synergistic partnership with the CEO and executive management. It will not be a relationship based mainly on supervision, but one in which the board engages with the CEO and executive management to achieve outstanding results.

Even though a board delegates its authority to the CEO it cannot delegate its accountability.

## CEO Performance management[[3]](#footnote-3)

The CEO performance appraisal is an important board responsibility and should take place on an annual basis. Further, the appraisal should reflect the priorities in the SoP (or other agreement/s with DHHS). This appraisal provides:

* important feedback to the CEO about their performance
* increased understanding of the CEO’s concerns and views on the achievement of corporate objectives
* a forum to build a healthy relationship between the board, especially the chair and the CEO
* a framework for the CEO to further develop capabilities
* a forum to reinforce accountability, transparency and the responsibilities of the CEO
* an opportunity to identify and address early warning signs of possible difficulties
* an opportunity to discuss any future plans the CEO may have (e.g. retirement)
* ability to meet requirements of the Enabling Act.

A robust appraisal process should be established that reflects the health service’s unique circumstances. This work is generally the responsibility of the CEO appointment committee, which will make recommendations to the entire board.

A more accurate picture of CEO performance can be gained by incorporating the views of several groups. For example, directors, executive management, DHHS, customers, suppliers and other key stakeholders will all have a view on the CEO’s performance. This must be handled sensitively, and all comments treated confidentially to uphold the integrity of the appraisal process.

Both quantitative and qualitative indicators may be included to assess the CEO’s leadership behaviour and performance goals. Using only financial, operational and clinical performance measures is inherently problematic.

There is an array of factors outside the direct control of the CEO that can affect organisational performance. A CEO may be performing strongly when the health service is not and vice versa. Also, stakeholder value can be measured from a number of perspectives, with startlingly different end results. In any event, CEO performance should be measured not only against short-term financial performance, but also on the CEO’s own performance, especially against agreed key performance indicators and strategic objectives.

### Professional development and support

A key element of attracting and retaining a good CEO is the provision of a professional development plan and other supports. Formal professional development, training and memberships/professional affiliations are often included as part of the CEO’s total remuneration package (TRP). Regardless, the board should consider not just how the CEO is performing but what supports could/should be in place to obtain the best performance from the CEO. Many supports are available without formalised costs (such as peer networks) others will have a time and financial cost (such as a course).

Supports that the board should consider for the CEO and executive team include:

* Mentor[[4]](#footnote-4) and/or coach
* Professional affiliation with member based organisations that enable access to professional development to maintain technical skills
* Membership with a peak body for executives, for example the Australasian College of Health Service Management (ACHSM), to provide access to professional development and supports for health CEOs and executives
* Networks across the primary expertise/discipline to enable best practice knowledge sharing (e.g. if the executive has a law background, membership with the Law Institute of Victoria may assist the executive in maintaining the currency of their skills)
* Networks to key organisations with relationships with the health service (for example, the PHN in the catchment area)
* Health and wellbeing support (such as mindfulness training, mediation, personal support networks, fitness)
* A professional development plan that includes regular opportunities to attend learning and networking opportunities.

The above supports are also critical for emerging talent as it is identified to allow the health service to support the transition to leadership.

## CEO succession planning

The purpose of succession planning is to ensure the board always has available a number of successor candidates in the event that the incumbent CEO departs suddenly and unexpectedly. Ideally, succession planning should start from day one of a new CEO’s appointment.

Managing CEO departures – whether due to tenure being reached or underperformance – can take time. It is important to be aware of the time involved and to ensure that there is a succession plan and appointment process running parallel to the exit plan.

In some cases, CEOs do underperform. When this happens, it is the board’s responsibility to manage the transitional arrangements. When done well, this process can be done with professionalism, respect and minimal disruption to the organisation’s operations.

The needs of health services are unique and often change over time, as does the available pool of talent from which a new CEO may be drawn. The board should ask the CEO to provide an assessment of the key internal contenders and what is being done to develop their strengths and overcome any limitations.

Some organisations approach succession planning by considering different contingencies, ranging from crisis management (e.g. if something untoward were to happen to the CEO, could the organisation continue to operate successfully?) to long-term issues (e.g. are we attracting, developing and retaining individuals to be future leaders in 3 to 5 years?).

At the heart of CEO succession planning is the notion that the board and the CEO work in cooperation to attract, develop and retain high performers who can be tried and tested prior to possibly being offered the CEO role in the future.

### CEO tenure

In the lead up to the expiry of a CEO’s contract, the CEO must undergo a performance assessment prior to any recommendation to re-appoint (which must then be approved by the Secretary). If the contract expiry is approaching (or past) the CEO’s tenth year, the HEER policy requires the board to undertake market testing. A market testing plan must be developed and a review panel convened to consider the outcome of the market testing. That review panel includes representatives of the department.

The board can recommend the reappointment of the current CEO to the Secretary if the review panel considers that they are the strongest candidate.

After the initial market testing at the 10 year threshold boards will be required to re-test roles by way of an open and competitive process at seven years of further service (seventeen years’ service in total) by an incumbent CEO and then at every three years of further service thereafter (that is, at twenty years’ service, twenty-three years’ service, twenty-six years’ service and so on).

Only the Secretary can approve the appointment or reappointment of a CEO.

The issue of tenure is not simply about renewal. It is about the independence of the executive from the board and ensuring the board maintains a clear vision for the future of the organisation it oversees. Recruitment of the CEO requires honesty, openness and transparency to ensure integrity in the recruitment process. By ensuring an open, merit-based process has been followed, without bias or impartiality, you promote public confidence in the decision-making of your board.

As boards are required to ensure that the health service performance meets the objectives of the Enabling Act, the appointment, retention and replacement of CEOs is an important board function. Boards must be prepared to replace a CEO if they consider that they are not performing, or believe that future performance may not be up to the level expected or in the best interest of the strategic goals of the health service.

Investment in the CEO and management team is crucial for the creation of sustained value. For this reason, directors need to commit considerable time and effort to CEO selection. This should be supplemented by appropriate mentoring, development, encouragement and support; a role often fulfilled by the chair.

When CEO performance concerns arise, these should be formally discussed and addressed promptly. If it is clear that the CEO is not delivering and needs to be replaced, then the board should act without delay. Whilst the cost of replacing a CEO is considerable, the cost of not acting can be devastating for the health service’s ability to provide safe, high quality care, meet financial performance measures and ensure compliance with its legislated obligations to the Minister and the public.

## CEO appointments and reappointments (contract renewals)

The Enabling Act requires that the board appoints the CEO and determines their remuneration, subject to the HEER Policy and approval of the Secretary.[[5]](#footnote-5) The selection of a CEO is one of the most important tasks a board can undertake. It is also probably the most difficult. Boards should drive the succession process, although normally in collaboration with the incumbent CEO. Boards sometimes select a CEO heir-apparent well in advance of the incumbent CEO’s planned departure.

For health services with good succession planning, the selection of a CEO may appear almost automatic with a suitable successor long identified. However, as executives become more mobile and the typical CEO’s job tenure continues to shrink, conventional succession planning may not identify an unequivocally acceptable internal candidate.

No board director will be considered for a CEO position of their health service due to the inherent conflict of interest that this creates.

Similarly, for many health services in regional and remote areas, identifying appropriately skilled CEOs can be particularly challenging. Many boards will need to look not just beyond the health service’s own executive ranks, but much further afield, if they are to find the best available CEO.

The board must ensure that robust processes are adhered to in the lead-up to the appointment. Experience suggests that the probability of a successful outcome is enhanced if boards follow a structured appointment process.

Confidentiality is critical throughout the appointment process. Any breach will deter potential candidates and reflect poorly on directors and the organisation as a whole.

The HEER policy has specific guidance on the process for recruiting a health service CEO.

The party, terms, conditions and remuneration for all CEO appointments, reappointments, contract variations and renewals require the Secretary’s approval.

## Executive remuneration policy

Pursuant to the Enabling Acts, the boards of all health services, VIFMH and AV are responsible for appointing the CEO and determining, subject to the Secretary’s approval, the remuneration and terms and conditions of appointment.

The salary and terms of appointment for the CEO and other executives must be consistent with the Government’s HEER policy. Boards are responsible for ensuring their health service adheres to the policy and that approval and reporting requirements are observed. It is recommended that boards and CEOs familiarise themselves with the policy.

The policy provides the Victorian Government with a tool to ensure health entity executive remuneration is not excessive and, where increases are appropriate, that they are broadly in line with wage movements in the general community.

## Useful references

* James Beck and Garth Paton (of Effective Governance), *CEO performance reviews that work* (May 2013) Effective Governance [www.effectivegovernance.com.au/ceo-performance-reviews-that-work/](http://www.effectivegovernance.com.au/ceo-performance-reviews-that-work/)
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* Victorian Leadership Academy, *Development Resources* (2017) <https://vpsc.vic.gov.au/leadership-academy/development-opportunities/>
* Women and Leadership Australia, <https://www.wla.edu.au/>
* Leadership Victoria, *Leadership Programs*

https://www.leadershipvictoria.org/programs-events/

1. Please note, these acts may have been amended and/or updated after this Toolkit was published. When reviewing, please review the most recent version. [↑](#footnote-ref-1)
2. The number and type of members of the executive team is health service specific. Some smaller services may only require the CEO and one other executive. [↑](#footnote-ref-2)
3. The HSA requires formal annual performance assessment of the CEO by the board in line with the KPIs in the SoP. Refer to HSA sections 33(2)(f), 65S(2)(f) and 115E(2)(i); ASA section 18(1); MHA section 332A. [↑](#footnote-ref-3)
4. See, for e.g., Australasian College of Health Service Management (ACHSM), *Mentor Guide* (2018). [↑](#footnote-ref-4)
5. Contracts must not be signed in advance of receiving Secretary approval. [↑](#footnote-ref-5)