Governing for quality and safeguarding: What might disability service provider boards learn from others?

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Demands of commissions of inquiry, legislators and regulators that disability service providers' boards of directors have greater involvement in the governance of quality and safeguarding have been increasing, both in Australia and overseas. However, there is no empirical literature on how disability service provider boards might govern for quality and safeguarding. In contrast, there is a substantial literature on the impact of boards on the quality of care in the hospital sector and a small but developing literature on board influence on work health and safety. This article examines what might be learnt from the both literatures and considers what findings might – and might not - be hypothesised to be transferable to the governance of disability service providers. Further, the article outlines a model for researching the boards of disability service providers and their influence on quality and safeguarding, and contributes ideas towards a research agenda.

Keywords: governance; board of directors; quality; safeguarding; safety

Introduction

Over the last thirty years or so, boards of directors - including those of providers of services to people with intellectual and other disabilities - have been advised to focus on

strategic issues and that they should 'govern more and manage less' (Chait, 1993; Ingram, 1996). One of the consequences of this approach is that boards have avoided being too involved in operations, with the perhaps unintended consequence that they have avoided or at least been hesitant about governing the quality and safety of their organisation's service delivery. However, more recently, commissions of inquiry, legislators and regulators have asserted that boards of directors as groups, and directors as individuals, should be active in the prevention of abuse and neglect and in the promotion of quality and safeguarding. For example, in several of the public hearings of Australia's Disability Royal Commission questions have been asked about: whether boards of directors include people with disability (including people with intellectual disability); whether boards have directors with expertise in preventing and responding to abuse and neglect; whether directors spend sufficient time in the field talking to the people supported and to staff; and, whether directors are adequately informed about their organisation's service delivery (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2022a, Public Hearings 3, 13 and 20).

This view, that boards are ultimately responsibility for their organisation's service delivery, has been stated by other Royal Commissions and Commissions of Inquiry (Charity Commission for England and Wales, 2020a; Francis, 2013; Royal Commission into Aged Care Quality and Safety, 2021; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017; Royal Commission into Misconduct in the Banking Superannuation and Financial Services Industry, 2019; The Bristol Royal Infirmary Inquiry, 2001). In part because of these pronouncements, legislators have also started to be active in this arena. When Australia's Parliament introduced quality and safeguarding arrangements into its *National Disability Insurance Scheme Act 2013*, it introduced the concept of 'Key Personnel' of a registered provider,

which includes members of board of directors (s. 11A). For a provider to be registered and remain registered under the Act, the Key Personnel must be and must remain suitable (*NDIS (Provider Registration and Practice Standards) Rules 2018*, ss. 10 and 13A). In further amendments to the Act in 2021, the legislation now allows for the NDIS Code of Conduct to apply to members of providers' boards of directors (s. 73V). The Code includes a requirement that "supports and services [must be provided] in a safe and competent manner, with care and skill". Depending on how the Code is amended following changes in the Act, this potentially opens directors to personal liability for civil penalties of up to $55,500 (as of February 2022) if they are in breach (NDIS Act, s. 73V) (Author's article, under review). Legislators have also created the regulatory systems which include quality standards about governing for quality and safeguarding.

Regulators have also been active. In Australia, the NDIS Quality and Safeguards Commissioner has issued the NDIS Practice Standards and the associated Quality Indicators, which state a series of requirements about provider governance and the governing body. The relevant Standard is that "Each participant's support is overseen by robust governance and operational management systems", with the most relevant Quality Indicator being that "A defined structure is implemented by the governing body to meet a governing body's financial, legislative, regulatory and contractual responsibilities, and to monitor and respond to quality and safeguarding matters associated with delivering supports to participants" (*NDIS (Quality Indicators for NDIS Practice Standards) Guidelines 2018*, Clause 11(2)).

In summary, commissions of inquiry, legislators and regulators have all emphasised the importance of boards of directors of disability service providers governing for quality and safety. However, despite extensive searches, the author has

been able to find no empirical evidence about how the boards of disability service providers should undertake this task. Nor is their empirical evidence about whether board involvement ultimately improves service delivery by disability service providers. To the extent that there is guidance, this is in the so-called 'grey' literature from consultants (e.g., Purpose at Work, 2022) and professional organisations (e.g., Australian Institute for Company Directors, 2021).

However, there are two bodies of related literature. First, there is the literature on the boards of hospitals and the health sector and how they govern for quality and safeguarding and with what outcomes. Indeed, the earliest assertions of board responsibility for quality have been in the hospital sector (e.g., Francis, 2013; The Bristol Royal Infirmary Inquiry, 2001) and there has subsequently been considerable empirical studies on these issues. Second, there is a small but growing literature on how boards govern for work health and safety (also known as occupational health and safety in some locations). In some jurisdiction, work health and safety legislation applies not just to workers, but to anyone in a workplace, including people being supported in the case of disability service provision. Further, in Australian States and Territories - other than Victoria - directors have 'due diligence' responsibilities such as keeping up to date with work health and safety matters and ensuring that resources and processes to reduce risk are used (Safe Work Australia, 2019).

The aim of this article is to report the empirical findings concerning health boards and of board governance of work health and safety and to consider what findings might be relevant to the boards of disability service providers. Second, the article offers a model for board influence on quality and safeguarding and tentative ideas towards a research agenda. As such the article is conceptual in nature, aiming to "bring new ideas

… to the field of intellectual disability, by drawing on … frameworks that are not generally used" (Bigby, 2014, p. 2).

Method

Given that there is no relevant literature on boards of disability service providers, the purpose of the paper is to provide a starting point for research by exploring what might be learnt from the literature on board governance of quality and safety in hospitals and that on board governance of work health and safety. Given this limited purpose, the research proceeded by locating literature reviews in these two areas. In the case of boards of hospitals, a search of academic data bases located three review articles: those of Erwin and colleagues (2019), Millar and colleagues (2013), and that of De Regge and Eeckloo (2020). The reviews of Erwin and colleagues and De Regge and Eeckloo were on hospital governance generally but with specific mention of quality and safety issues; in contrast, Millar and colleagues' review focused on quality and safety in particular. Although not a review article, Mannion and colleagues' (2018) book chapter on their reflections as leading researchers in the area is also useful. In health care, governing for quality and safeguarding is known as 'clinical governance'.[1]

The literature in relation to work health and safety includes only one review article, that of Ebbevi and colleagues (2021). However, Ebbevi and colleagues argue that "the true challenge" remains of identifying "the activities that add substantial value to OHS" (Ebbevi et al., 2021, p. 80).

Table 1 gives more detail on the four studies. With the exception of Millar et al. (2013), the review articles have the advantage of all being published recently, thus

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[1] Related terms which might be used are 'care governance' in aged care or 'practice governance' in disability service provision.

giving insights into the latest research in relation to the issue. For both literatures, this article draws on the four key reviews cited, plus selective use of the articles they cite.

Table 1. Literature reviews

Review articles	**DeRegge & Eeckloo, 2020**	**Erwin et al. (2019)**	**Millar et al. 2013**	**Ebbevi et al. 2021**
Area	Hospital governance generally	Hospital governance generally	Hospital governance, specifically quality and safety	Work health and safety
Title	Balancing hospital governance: A systematic review of 15 years of empirical research	Effective governance and hospital boards revisited: Reflections on 25 years of research	Hospital board oversight of quality and patient safety: A narrative review and synthesis of recent empirical research	Boards of directors' influences on occupational health and safety: a scoping review of evidence and best practices
Review style, as stated in the article	Systematic	Not stated	Narrative systematic	Scoping
Inclusion and exclusion criteria	"(a) they were written in English; (b) they were published in peer-reviewed scholarly journals; (c) they appear after 2002 (2003–2018); (d) empirical research study, including the following variables: hospitals or health systems and governance characteristics or practices. The criteria for exclusion were: (a) not describing governance characteristics or practices; (b) studies of developing	"(a) English-language publications; (b) appearing in peer-reviewed, scholarly journals; (c) published after 1990 (1991-2017); (d) U.S. hospitals and health systems; (e) empirical research study; (f) board of directors construct(s) used as either dependent or independent variable; and (g) strategic management and/or organizational effectiveness or performance construct(s) used as either	"… we concentrated on those that considered board oversight in the context of quality and safety … The team drew up a list of key terms and searched the published literature from 1991 to the present across a number of databases, excluding articles not written in English." (p. 742)	"Inclusion criteria were publication in English. Exclusion criteria were studies covering companies using subcontractors to arrange OHS, or with <250 employees." (p. 64)

	countries (c) or of macro-level governance; (d) studies of the governance of specific institutions (e.g., governance of academic medical centers); (e) conceptual frameworks not relying on new empirical data; and (f) unauthorized work, editorials, perspectives, comments, letters, conferences, and proceedings." (p. 2)	dependent or independent variables." (pp. 135-136)		
Number of studies reviewed	63	51	122	49
Key findings	"There is a lack of consistency in the research findings on attributes and there is too little research into the dynamics and processes of hospital governance. However, it has been shown that clinical participation on the hospital board and the focus on quality in hospital board roles can have a beneficial effect. The studies do not provide sufficient direction on	"… research on board effectiveness is intimately linked to organizational performance. Without a uniform measure of either concept, it is difficult to draw broad conclusions. Organizational factors and the external environment also likely play a role in attributes of effective boards." (p. 155)	"Our review has captured some of the key areas in which boards may be able to develop greater expertise, through, for example, the provision of better information and education for board members in using data to inform decision making. Our review also indicates that efforts to create effective governance for quality and patient safety remain variable	"Empirical studies gave no insight into the scope of impact of board activities on OHS, and no studies assess the causal mechanisms by which board activities influence OHS outcomes … Several studies are describing leadership behavior, although not framed as such." (p.64)

	what best practice for governing hospitals should be." (p. 2)		and are only just beginning. Future work in this area is required, focusing on which available conceptual models provide appropriate bases for action and whether empirical studies of board oversight practices associated with good patient safety outcomes can be adequately theorized and translated across different settings." (p.764)	

The literature on governing for quality in health care

There are three key questions that can be asked of the literature on governing for quality in health care. The first question - and what might be considered the key question - is: Is there an association between board-level governance, on the one hand, and quality outcomes and patient outcomes, on the other? The term ‘quality outcomes’ includes the adoption of particular quality practices at the hospital level, or the achievement of quality accreditation or ratings within those accreditation schemes. Patient outcomes include morbidity (illness) and mortality (death). An example of a morbidity indicator is the requirement for readmission for treatment for the same condition, which suggests that the first treatment was not fully effective. Mortality indicators can be general, or they can be specific, such as death from a specific cause.

In the hospital environment, there are likely to be many factors that influence quality outcomes or patient outcomes. One likely influence is the quality of the medical, nursing, and allied health staff, including their formal education and their years of experience as practitioners. The treatments and practices in use, and whether they are consistent with evidence-based practice, will clearly be important. The amenity of the hospital is likely to play a part. On top of this, the management and leadership of the hospital, and the role of the hospital’s CEO, senior management and quality and safeguarding specialists, are likely to be important. Finally, there is the role of the board. If the board has an impact, it is likely to be relatively small, given the long chain of causation between boards and patients.

Given this context, it is noteworthy that the three review articles do conclude that there are small but statistically significant relationships (Brown, 2020) between board governance and quality and patient outcomes. Studies by Jiang et al. (2009) and Jha and Epstein (2010) are frequently cited in the reviews. Jiang and her colleagues

demonstrated correlations with both process of care measures for heart attack, heart failure and pneumonia) and risk adjusted mortality and:

- provision of clinical quality data, including national benchmarks
- provision of patient safety data, including national benchmarks
- provision of patient satisfaction data, including national benchmarks
- most board meetings having a specific agenda item on quality
- CEO and executive performance evaluation including measures for clinical improvement and patient safety
- establishing strategic goals about quality, and
- board involvement in setting the organisation's quality agenda.

Other correlations were demonstrated for either process of care measures alone or risk adjusted mortality alone.

Jha and Epstein (2010) examined correlations between board processes and high and low performing hospitals using process of care measures. They found that high performing hospitals were:

- more likely to have received formal training in clinical quality
- more likely to have quality performance on the agenda of every board meeting
- more likely to spend at least 20 per cent of board time on clinical quality
- less likely to spend at least 20 per cent of board time on financial performance
- more likely to have a quality sub-committee
- more likely to review quality dashboards regularly, and
- more likely to review a range of specified quality data, including on infections, medication errors and patient satisfaction.

Of course, the demonstration of associations between variables (correlation) in cross-sectional studies (i.e., studies at a single point in time) does not demonstrate

causation. Longitudinal studies can demonstrate causation, but at this stage none have been reported.

The literature on governing for work health and safety

In comparison with the literature of hospital boards and their impacts, the literature on boards and work health and safety is at an early stage, with no evidence on links between board practices and outcomes (Ebbevi et al., 2021). Research has been reported in relation to responsibilities, competence, organisational culture, strategy, performance management, internal controls and committee structures (Ebbevi et al., 2021). Strategies which are pursued to promote board influence on work health and safety are:

- board-level attention, which then instigates attention at lower organisational levels (Lornudd et al., 2021)
- board-level committees, with cascading committees at lower levels
- a dedicated director portfolio for work health and safety
- director training in work health and safety, including assessment of director competency
- director site inspections
- the promotion of a safety culture
- enunciating a vision for work health and safety and determining policies
- monitoring a mix of performance measures, including measures about process (e.g., training), outcome measures (e.g., absences from work) and ‘strategic’ measures (e.g,, safety culture)
- incentives for senior management, and
- regular reporting, including from internal and external sources, including benchmarking comparison (Ebbevi et a. 2021).

As the authors conclude, the research on board influence on work health and safety is "in its infancy" with additional research needed "on which board activities influence OHS [occupational health and safety], how board activities influence OHS, the influence of context and the role of the board of director's leadership (Ebbevi et al., 2021, p. 81).

Are the findings in hospitals and work health and safety likely to be transferable to the disability sector?

It might be hypothesised that findings in relation to the governance of hospitals and work health and safety, such as they are, might equally apply to disability service providers. However, there are reasons to be cautious when making such hypotheses. First, there are contextual differences. Hospitals and the organisations in scope for the Ebbevi et al. (2021) study are often large and very large organisations, with substantial internal resources to allocate to quality and safeguarding. However, many disability service organisations – at least in Australia - are small and, if complaints about NDIS pricing are correct, likely to have significant resource constraints (National Disability Services, 2021).

Further, scale can sometimes enable learning by making identification of problems easier: for example, in an organisation with a turnover of $10 million, 10 instances of a particular problem might suggest a trend that needs to be addressed. However, in a smaller organisation, say with a turnover of $1 million and the same incidence rate, there will only be one instance and no trend might be able to be identified. Associated with this, goal setting and planning to improve quality and safeguarding are probably more meaningful activities in large service systems, whereas they might be more difficult in the context of small numbers.

Second, although hospital systems are diverse (reflecting different degrees of surgical and medical care, psychiatric care, etc.), they all have a similar operating model based around professional service being delivered in institutional settings. However, the operating models for disability support are diverse, ranging from the fully professionalised early intervention models for children with disability, through to support work in the community where workers might not have any formal qualifications, and from traditional employment models to platform employment.

Third, anecdotally, directors of health boards and of for-profits are likely to be paid, whereas this might not be common in not-for-profit disability service providers, at least in Australia. Potentially, this has implications for director skill levels and willingness to devote time and attention, although it should not be assumed that remuneration of directors results in superior board performance.

Fourth, at least at the time of writing and in the Australian disability services sector, there are no widely available benchmarking reports on general quality and safeguarding. The benchmarking services that exist in Australian disability services are limited to commercial services which at this time have relatively low uptake and do not report outcome data on a risk-adjusted basis.[2] As the review articles noted, the availability and use of benchmarking data is identified as being of key importance in board influence on quality and safeguarding.

The final point to be made is not about the difference between the sectors, but rather the potential for similar practices to be adopted for reasons other than their

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[2] General exceptions are Ability Roundtable and Moving on Audits; LaTrobe University also has a benchmarking study for Person-Centred Active Support in group homes for people with intellectual disability.

evidentiary value. The theory of 'institutional isomorphism' suggests that practices can be transferred from one organisation to another for coercive, mimetic and normative reasons rather than because of their demonstrated efficacy (DiMaggio & Powell, 1983; Meyer & Rowan, 1977).[3] Coercive forces are those associated with legislation and regulation. Mimetic forces are those which result in copying of practice from one organisation to another, such as might occur when a director with an allied health background applies similar practices to those used in healthcare to a disability service provider board. Normative mechanisms include the role of professional associations or consultants; in the current case, there is the role of the professional associations such as the Australian Institute of Company Directors and the Australian Institute of Clinical Governance and of consultants working across both sectors in promoting the concepts and practice of clinical governance.

Thus, it should not be assumed that the findings in the health sector and about work health and safety are necessarily transferable to the disability sector. There is a need for research of practice on the boards of disability service providers, research which is informed by the factors mentioned in this section.

Towards a conceptual model and research agenda

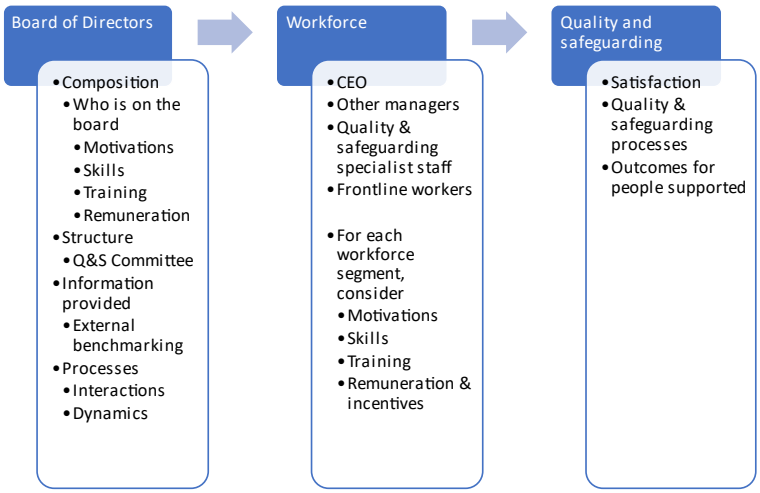
There is a lack of basic descriptive data about board engagement in quality and safeguarding in the disability sector, such as: the time devoted in board meetings to discussing quality and safeguarding; the number of board members with relevant expertise; whether there is a board committee dedicated in whole or part to these issues;

[3] It is acknowledged that this is not institutional isomorphism as classically understood as the ideas are being transported across fields rather than within the same field.

what performance measures in quality and safeguarding are used, if any; and whether boards have received training in quality and safeguarding. Thus, early research efforts might be devoted to collecting and analysing that data along the lines of the work of Joshi and Hines (2006) and Jha and Epstein (2010) in the USA or Bismark and colleagues in Australia (Bismark et al., 2014; Bismark & Studdert, 2014).

Conceptually, board influence of quality and safeguarding might be conceived in the manner suggested in Figure 1, with a research agenda being built from this model. At a broad level, boards of directors presumably have very little *direct* impact on quality and safeguarding outcomes; after all, they are involved in governing rather than direct service delivery. Their influence will be achieved through the workforce, as variously constituted.

Figure 1: A model of board influence on organisational quality and safeguarding



Relevant factors at the board level might include the composition of the board, its structure, the information it receives, and it processes. Under composition, relevant considerations are likely to include the professional and demographic composition of the board, directors' skills, whether directors have had training in quality and safeguarding, and possibly whether directors are remunerated. There is also the question of whether the inclusion of directors with disability, including directors with intellectual disability, improves influence in quality and safeguarding, an issue which will be discussed in more detail shortly. Board structures will vary depending on organisational size and history, but if might be that boards which have dedicated committees on quality and safeguarding have more impact on the organisation's achievement of quality and safeguarding. Information provision, including the provision of benchmarked data, appears to be important. In can be hypothesised that board processes and dynamics will also be important, including such questions as the amount of board time and attention allocated to quality and safeguarding issues, and the overall effectiveness of the board in translating concerns into decisions into action.

Board impact on quality and safeguarding appears to be mediated through the workforce. Underlying motivations, such as the degree to which staff members have pro-social motivations, are likely to be important. The pre-existing skills of the workforce, in all its forms, and subsequent training are also likely to be significant. The degree to which CEO and other managers of disability service providers have additional financial incentives is not known; however, the literature on hospitals suggests that where financial incentives are provided criteria for their payment should include quality and safeguarding achievements. It would be important to consider the impact of quality and safeguarding specialist staff, and to consider the nature of the interactions between directors and such staff. Although Figure 1 suggests that the direction of causality is

from the board of directors to the workforce, for the CEO, executive management, and quality and safeguarding specialist staff, it is possible that the direction of causality is the reverse: that CEO, executive managers or specialist staff engage the board in discussions around quality and safeguarding because of their personal motivation to promote these. Indeed, it is possible that there is a 'virtuous spiral' in operation, with the CEO promoting board attention to quality and safeguarding issues, with directors through processes of questioning and discussion then prompting the CEO to think more deeply and to take more action on quality and safeguarding, and so on.

In terms of outcomes, similar to the literature on hospital governance, outcomes could be studied as satisfaction levels, process outcome levels and the outcomes for people supported. However, the difficulty of identifying and accessing data on process outcomes and outcomes for people with disability should not be underestimated. At least in the Australian disability system, unlike in the hospital sector, there are no universally accepted process and end-user outcome measures. In those systems where rating scales are used (e.g., the English Care Quality Commission ratings), the rating provided could be used as a process outcome measure. However, it is known that such ratings do not necessarily correlate with the real-world experiences of the clients supported: it is important that the actual experience of the clients be considered (Beadle-Brown et al., 2008; Murphy, 2020).

Contextual issues that should be included as control variables include organisational size, financial wellbeing, support types, and potentially organisational status as a for-profit or not-for-profit. Organisations of greater size probably are likely to have specialist board committees (including committees dedicated to quality and safeguarding) than small organisations where all governance business might be transacted by the board. As previously argued, increased organisational financial

wellbeing also means that there are more resources available to allocate to improved quality and safeguarding. Support types can be important because of the inherent risks of providing those supports; also, they can be relevant because some support types might be more financially sustainable than others. Finally, theory suggests that not-for-profit organisations are more likely to invest in and achieve high quality services than for-profits (Hansmann, 1980); the empirical evidence across a range of sectors produces nuanced results, sometimes supporting this theory and sometimes not (Anheier, 2014).

All the review articles give suggestions for future research, and the discussion now draws on these. One of the clear omissions in the hospital sector is longitudinal studies which will help answer the question of causation. Other areas suggested in the review articles for further research are: exploring the challenging issue of board influence on organisational culture (Ebbevi et al., 2021), which would need to consider the specific circumstances of disability service providers; analysing the impact of the relationship between the board and the CEO and executive management, including the intriguing question of "whether more oversight is better, and under what circumstances" (Erwin et al., 2019, p. 160); and, research -including action research - on the translation of board oversight practices across a diversity of settings (Millar et al., 2013).

There is one aspect of the boards of disability service providers that is in some ways unique to this sector, namely the demand to include people with disability on boards, including in the case of providers serving people with intellectual disability the demand to include directors with intellectual disability. This is in part motivated by the demand of advocates for 'nothing about us without us'. Australia's Disability Royal Commission, in response to one case of abuse, asserted that this is likely to lead to improved quality and safeguarding (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2022b). While there is no doubt that some

people with disability, including people with intellectual disability, can and do play valuable roles on boards, it is arguable that - at least in some organisations - governance involves tasks of considerable cognitive complexity and that many people with intellectual disability might not be appropriate matches to the task of governance even with support. Moreover, inclusion of people with disability is not by itself sufficient to prevent abuse and neglect, as demonstrated by the scandal concerning the Royal Institute for Blind People in Britain (Charity Commission for England and Wales, 2020a). The charity regulator described the RNIB as "one of the worst examples we have uncovered of poor governance and oversight" (Charity Commission for England and Wales, 2020b), despite the board being entirely composed of disabled people. Although there has been some research on inclusion of people with intellectual disability on boards (e.g., Beckwith et al., 2016), this research seems to be predicated on the assumption that inclusion is a good thing of itself and to be focused on the issue of how to include directors with intellectual disability more effectively. However, there has been no research on the effect of including people with intellectual disability on both board performance and organisational performance.

Conclusion

Commissions of inquiry, legislators and regulators, both in Australia and overseas, have been given increasing attention to the role of boards of disability service providers in governing for quality and safeguarding. However, apart from assumptions made based on single case studies (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2022b), there is a lack of evidence about how disability service provider boards might influence quality and safeguarding. The literatures on boards of hospitals suggest that disability support provider boards might indeed have a positive influence. Both this literature and that on boards and work health

and safety suggest practices to achieve such influence. However, as identified in the article, there are reasons to be cautious about assuming that these findings are directly transferable to the disability sector.

Clearly, there is a need for research that is specific to the boards of disability support providers. Researchers on disability service provider boards have the advantage of learning from the work of their peers on hospital boards and work health and safety and this could accelerate the research process and could improve the quality of insights generated. The article has suggested a model of board influence on quality and safeguarding which researchers might utilise and build upon, and has also identified issues for particular focus in the research. Improving the quality of supports provided and improving safeguarding are important issues with real world consequences for people with disability; therefore, government and organisation strategies to promote quality and safeguarding should be research-based to ensure that time, attention are resources are being devoted to those strategies which will have most impact.

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