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## The role of governing boards in improving patient experience: Attitudes and activities of health service boards in Victoria, Australia

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### Abstract

The authors sought to determine the attitudes of public health service board members and senior executives toward patient experience and to describe the governance activities of the boards in this area. The study was based on an online survey of 322 board members from 85 public health services and semi-structured interviews with 35 board members and senior executives from 13 public health services in Victoria, Australia. The results showed that while some health service boards had high aspirations and clear plans for improving patient experience, others remained sluggish or even cynically resistant to changing their existing models of care. Interviewees associated with highly active boards described initiatives to improve patient experience at multiple levels in the organisation - from boardroom to bedside. Among less active boards, efforts to improve patient experience tended to be more ad hoc and there was greater uncertainty about how to scale up or systematise. The authors conclude that addressing the gap between the responsibility of boards to address patient experience, and the reality of their governance activities, requires a nuanced understanding of the attitudes and activities of board members. The approaches taken by “positive attitude, high activity” boards could be showcased as exemplars for others.

### Keywords

Patient experience, governance, boards, quality of care, patient rights, patient-centred care, consumer engagement

### Introduction

Positive patient experience is increasingly recognised as a vital component of high quality care.<sup>1-5</sup> There is also a strengthening focus on the need to hold boards of health services accountable for the quality of care their organisations deliver.<sup>6,7</sup> At the intersection of these two developments is the growing recognition that the task of safeguarding and improving patient experience does not fall solely on frontline clinicians - it is a core governance responsibility.<sup>8,9</sup> The recent Francis Inquiry in the United Kingdom exemplifies heightened expectations in this area. It found that the suffering of patients treated within the Mid-Staffordshire Trust was “primarily caused by a serious failure on the part of a provider Trust Board [which] did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention.”<sup>10</sup>

Internationally, a number of initiatives aim to promote board engagement in improving patient experience. Such engagement can occur at many levels: from nurturing a culture of patient-centred care<sup>11-13</sup> to facilitating consumer participation in systemic improvements in care planning,

design, delivery and evaluation.<sup>8,14</sup> For example, in the United Kingdom, a quality standard articulates healthcare leaders’ responsibility to support a “cultural shift” towards being truly patient-centred.<sup>15</sup> In Australia, new national accreditation standards,<sup>16,17</sup> being implemented at the time of this study, prescribe certain board responsibilities that relate to improving the patient experience (see Box 1).

Initiatives along these lines are new and little is known about their uptake by boards. In one study of organisations with a reputation for improving the patient experience, interviewees repeatedly identified strong governance support as a critical facilitator of patient-centred care.<sup>18</sup> Yet, research in the United States and United Kingdom has shown significant gaps in board members’ understanding of quality and safety issues.<sup>19</sup> One qualitative study in the United States, which interviewed 26 hospital board members, found them hesitant to challenge hospital culture in the clinical domain.<sup>20</sup> In this study, we aimed to describe the attitudes of public health service board members and the activities of their boards in relation to patient experience in Australia.

**Box 1: National standards that relate to governance of patient experience**

<b>Criterion</b>	<b>Suggested board-level strategies for meeting criterion</b>
Patient rights are respected and their engagement in their care is supported	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights  Data collected from patient feedback systems are used to measure and improve health services in the organisation
Governance structures are in place to form partnerships with consumers and/or carers	Consumers and/or carers are involved in the governance of the health service organisation  The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation  Consumers and/or carers are actively involved in decision making about safety and quality
Patient safety and quality incidents are recognised, reported and analysed, and this information is used to improve safety systems.	Patient feedback and complaints are reviewed at the highest level of governance in the organisation

**Methods****Setting**

Our study took place in Victoria, the second most populous of Australia's six states with nearly 6 million residents. Victoria has 85 separate public health services, ranging from large metropolitan services with more than 500 acute care beds to small rural services with fewer than five beds.<sup>21</sup> Each health service is governed by a local board, comprising six to 14 non-executive directors, appointed by and accountable to the state Minister for Health.<sup>22</sup> Community health services were not included in the study.

**Study design**

The parent study was approved by Human Research Ethics Committee of the University of Melbourne. We collected data from two sources: quantitative data from a survey of health service board members, and qualitative data from interviews with board members and senior executives. The analysis reported here draws on data from both sources.

**Data sources**

In stage one of the study, conducted in March 2012, we surveyed four board members from each of Victoria's 85 public health services: the board chair, the chair of the quality committee, and two other board members randomly selected from among members with at least one year of service. Survey questions regarding patient experience addressed four domains: board member training, board priorities, board activities, and the perceived influence of boards on quality and safety of care. Of the 332 members

surveyed, 70% (233) responded and 96% (82/85) of boards had at least one member respond. Details of our sampling strategy and the development, content and administration of the survey instrument are reported elsewhere.<sup>23</sup>

In stage two of the study, conducted between September 2012 and January 2013, we conducted semi-structured interviews with 35 board members and senior executives from 13 of the 85 health services. Table 1 reports the characteristics of these interviewees. A stratified sampling design was used to select the health services in which interviewees were recruited, with strata based on the size and types of communities served. The interview schedule included a series of questions regarding attitudes and knowledge among board members in relation to factors influencing patient experience; it also sought information on board-level activities in this area. The interviews were digitally recorded and transcribed verbatim. To maximise candour, interviewees were assured confidentiality. Details of our sampling and recruitment strategy and interview schedule are available elsewhere.<sup>24</sup>

**Analysis**

We analysed the survey data by computing simple counts and cross-tabulations. Responses to questions about expertise, knowledge and attitudes were analysed at the respondent (or board-member) level. Responses about board activities were analysed at the board level. All statistical analyses were conducted using R version 2.15.1.<sup>25</sup>

**Table 1: Characteristics of board members and executives who were interviewed**

Characteristic	No of interviewees (n=35)
<b>Sex</b>	
Male	17
Female	18
<b>Position</b>	
Board chair	7
Quality committee chair	5
Board member	5
Chief executive	7
Senior executive	11
<b>Location</b>	
Metropolitan	6
Regional	16
Rural	13

The interview transcript data were managed using NVivo 9 software. We used thematic analysis<sup>26,27</sup> to identify major themes in the views expressed by interviewees. Specifically, two investigators (MB and DS) read and discussed the content of the first five transcripts, and identified the main themes. This formed the basis of a draft coding framework. One investigator (MB) then reviewed the remaining transcripts, applying and modifying the draft coding framework through an inductive and iterative process. The other investigator (DS) independently repeated this process for a subset of transcripts. The two investigators then discussed their coding framework and choices, with differences resolved by consensus. Finally, all coding was reviewed in light of these discussions.

## Results

### Attitudes and knowledge

Most of the data gathered on attitudes and knowledge in relation to patient experience came from the interviews. Several board members and executive managers commented on the increasing focus on patient and family experience in the health sector over the last ten years. This change was perceived as being driven from outside the health service, rather than being led by boards themselves. One interviewee commented: “The whole rhetoric around needing to be open to patients, being part of a team, being transparent about where we’re at and what we’re doing ... You know, the move, it’s coming, whether we like it or not.” (Quality Manager, regional) Another interviewee who had spent many years in the health sector contrasted today’s patients with those of the past, who would come in to hospital and say “oh yes matron, no matron, whatever you say matron” (Quality Manager, rural). Interviewees attributed changing patient expectations to a variety of factors, including “people taking more ownership of their

health” (Quality Manager, rural), a growing willingness to question the medical viewpoint, and the emerging international literature on the role of patient experience in care quality.

Some interviewees took a positive view of this change in patients’ expectations, and were enthusiastic about finding ways of integrating patient perspectives and experiences into their governance processes. In the words of one Chair: “It’s what we are all about ... Giving the very highest quality so we get the very, very best outcome for each of our patients and their families. And we’re constantly looking for ways of improving that.” (Chair, regional) Another interviewee noted: “Often people who don’t have that medical background ask the most interesting questions, very astute questions, because they haven’t got that sort of pre-judgement.” (Quality manager, regional). Interviewees from these boards seemed to value patients’ views and perceive them as having a strong influence on board decision-making.

Interviewees from other health services, by contrast, appeared more sceptical. Sceptics tended to espouse two inter-related views: cynicism and paternalism. The cynical view was that patient engagement is a fad that ought to have little impact on board decision-making. The paternalistic view was more nuanced. The concern was that most lay people “cannot cope with the complexity of a health organisation” (Quality Chair, regional) and that decision-making was best left to the board and clinical leaders. One Chair from the board of a rural health service said: “I think in a small country town people know everyone, so they know the people on the board and they probably say ‘Well, look, we’ve got confidence in them’.” (Chair, rural)

Whether such confidence was well-placed is questionable. Lack of knowledge and expertise about what matters to patients, and how these priorities could be integrated into governance processes and decision-making, were recurring themes in interviews. Several board members declared their lack of expertise in this area, with one noting: “Patient-centred care ... I think if we’re all honest, this is a real learning curve for the health sector.” (Chair, metro) Our survey findings also pointed to gaps in knowledge, with substantial proportions of board members unfamiliar with key policies, indicators, and standards related to patient experience. The vast majority were familiar with major Victorian documents, including the state Department of Health’s Quality of Care Report guidelines<sup>28</sup> (94% of members “somewhat familiar” or “very familiar”) and the Patient Satisfaction Monitor<sup>29</sup> (91%). However, board members were less familiar with major national documents relating to patients’ rights and experience of care: 46% of members were “not familiar” with the Open Disclosure Standard<sup>30</sup> and 37% were “not familiar” with the Australian Charter of Healthcare Rights.<sup>31</sup>

### Activities

Collectively, boards were engaged in a wide range of activities aimed at improving patient experience. However, activity levels appeared to vary considerably across boards. Based on our survey data, Table 2 reports the number of boards undertaking each of 6 activities that relate to patient experience.<sup>23</sup> Whereas a majority of boards (95%) reviewed data on patient and family satisfaction or experience at least annually, only half had developed or endorsed a strategy regarding communication with patients and families, and less than a quarter provided members with training on healthcare disparities.

Interviewees associated with highly-active boards described initiatives to improve patient experience at multiple levels in the organisation - from boardroom to bedside. One senior executive explained: “We have consumer reps on our quality committee. We’ve got a very active consumer advisory committee. And we have community representatives on our strategic planning committee. So there is direct input from our community into those three areas of our service and more. We also have community members undertake service reviews and seek consumer input into all consumer publications.” (Executive manager, regional)

Among less active boards, efforts to improve patient experience tended to be more ad hoc, and there was greater uncertainty about how to scale up or systematise these efforts. One chair recalled a conversation from the early days of their board’s journey towards improved patient-experience: “One board member - over the coffee break in our board meeting - says ‘I’m not sure that I really know what patient-centred care means.’ ... I don’t think there [was] any common understanding between the board and the executive about what we mean by patient-centred care.” (Chair, metro) Another board member acknowledged that his board’s links with the community “aren’t as good as they should be”. (Chair, regional) Other interviewees, particularly those from smaller health services, felt overwhelmed by the demands they faced across many facets of governance. Several explained that substantive attention to patient experience did not seem feasible while the board struggled with a fiscal deficit. One board member commented: “There has been a lot more focus on the bottom line.” (Chair, rural)

### Typology of engagement

In considering the range of attitudes and activities reported by survey respondents and interviewees, we identified four broad groups of boards. These groups are summarized in the two-by-two format of Table 3 and described below:

*High activity, positive attitude* – Boards in this group can be described as ‘talking the talk and walking the walk’ on partnering with patients. In the words of one Chair: “This is a major, major focus for the board – making sure that we are really person-centred”. (Chair, metro) Interviewees associated with such boards discussed a range of benefits that flowed from consumer engagement and patient-centred care including mitigating risks, improving patient outcomes, and increasing the responsiveness of services to patient needs. Even though these boards were usually doing more than others, they were also more likely to be alert to gaps in their performance, and to express a commitment to ongoing improvement. For example, one Chair from a board in this group pointed out that: “What you notice [in our board dashboard] is there’s nothing about patient experience” (Chair, metro) and went on to explain the board’s plan to develop improved patient experience measures.

*High activity, negative attitude* – These boards may be characterised as “ticking the box” on various consumer engagement activities, largely for the purpose of complying with external expectations. Interviewees from such boards were often cynical about the value of such activities, expressed paternalistic attitudes toward patient care and questioned the extent to which patient preferences should shape care delivery. One interviewee, in explaining his scepticism about sharing performance data with patients, commented: “Well, yeah, what are they going to say? I’ve come in with my appendicitis and the surgeon who is on tonight is not the one with the best figures?” (Medical Director, rural) Transparency with consumers was limited. One chair justified this stance by stating that “unless you sanitise [information] you’ll get someone out in the community that puts the wrong emphasis on it and is therefore critical to the health service.” (Chair, regional)

*Low activity, positive attitude* – Boards in this group believe in the importance of patient engagement and patient-centred care, but have not, by their own admission, taken many (or any) steps in this area. Common justifications given for the lack of activity included lack of funding for patient-centred models of care, difficulty finding consumers to serve on advisory committees, and more urgent issues to address. One board member explained: “We’ve got this development going on, so recently we’ve spent more time on the building projects.” (Board member, rural) The chief executive of another health service noted that her board was strong on financial oversight, but was still finding its way regarding patient experience: “I think we’ve got the other governance side of things, but there’s more in patient care that we need to do so we can get a more consumer focus.” (Chief Executive, regional).

**Table 2: Activities relating to patient experience undertaken by boards (n=82 boards)**

	<i>n</i>	<i>%</i>
Board reviews data on patient and family satisfaction or experience at least annually	78	95
Board strategic planning process involves consumers, carers or community groups	73	89
Board has established or endorsed goals relating to patient and family satisfaction or experience	68	83
Board has developed or endorsed a strategy relating to communication with patients and families	42	51
Board receives quality of care data analysed according to the cultural and linguistic background of patients	26	32
Board members receive training on healthcare disparities	18	22

**Table 3: Attitudes and activities of board members towards improving patient experience, with illustrative quotations**

	Attitude	
	Negative	Positive
Activity	More	“Consumer participation is a bit tokenish. We have a few consumers come and listen to a presentation on how terrific the hospital is. It doesn’t make much difference.” (Board member, metro)
	Less	“We have a volunteers group but we don’t meet with them and we don’t have a consumer advisor on our board. We had a subcommittee, but it hasn’t met.” (Board member, regional)

*Low activity, negative attitude* – Board members in this group did not see improving patient experience as a priority and reported relatively few activities in the area. One board member commented: “It’s not something that the community is saying, we want to see this, we want these answers, or anything like that.” (Chair, regional)  
 Interviewees from such boards largely favoured a traditional medical model of care. In response to queries about consumer representation in decision-making, several interviewees associated with boards in this group stated a belief that board members and clinical leaders could adequately represent the patient perspective. In the words of one Chief Executive: “We actually don’t have a community advisory committee because to have a formal community advisory committee wouldn’t be the best use of people’s time, because we see ourselves as the community because we employ a good cross-section of the community. We don’t need to go to that point.” (Chief Executive, rural)

**Enablers**

During the interviews, board members and senior executives were asked to nominate ways in which governance of patient experience-related issues had been (or could be) strengthened. Responses converged around five

themes: leadership, training, measurement, openness, and responsiveness. Illustrative quotes relating to each of these themes are provided in Table 4.

Strong leadership by a board chair or quality committee chair was identified by interviewees at four health services as pivotal in focusing attention on issues of patient experience. One board member described a profound change in organisational culture following the appointment of a chair and chief executive who are “completely and utterly driven by quality outcomes for patient care” (Board member, regional). The chair of another board’s quality committee described his role as follows: “You need to champion what’s going on in your community and the community needs, because your health service needs to reflect what the needs of the community are.” (Quality Chair, rural)

Training in patient-centred care and consumer engagement was identified as valuable for both board members and consumer representatives. One chair recalled that some members of his board had to be dragged “kicking and screaming” (Chair) to a session on cultural awareness, but later appreciated the benefits for improving patient

**Table 4: Enablers of board activity to improve patient experience, with illustrative quotations**

Enabler	Example quotes
<b>Leadership</b>	<p>“It’s really driven from the top. We’ve gone out and developed a whole strategy around how we measure patient-centredness. And yeah, that’s been driven from the board.” (Chair, metro)</p> <p>“[The Board] certainly continues to consider that. How do we ensure that consumers in our community have input into - not at the end, where they tick the survey - but input into the delivery of care.” (Quality Chair, regional)</p>
<b>Training</b>	<p>“That [board training on patient-centred care] was a really healthy process because it meant we were all then on the same page. And a whole body of work has flowed through that.” (Chair, metro)</p> <p>“[Members of the Consumer Advisory Committee] need to think about more systemic issues across the health service, and not just think about ‘I’m here to advocate for my particular constituency.’” (Chair, metro)</p>
<b>Measurement</b>	<p>“A hobby horse of mine is that we don’t walk away from this having terrific clinical indicators and forget that we’re here [because] people want to have access [to care] and they want a good experience.” (Board member, regional)</p> <p>“I think in future, when we get useful comparative information about outcomes, then consumers will be really interested ... But we just don’t have that sort of data publicly available yet.” (Quality Chair, regional)</p>
<b>Openness</b>	<p>“We’ve invited the community and representatives to [an open access] board meeting and there’ll be nothing held back because there is nothing to hold back.” (Chair, regional)</p> <p>“Would we mind if our ranking on measures against other hospitals was out in the public domain? I don’t think we would. As long as it was fair and we were comparing apples with apples.” (Chair, regional)</p>
<b>Responsiveness</b>	<p>“Our Community Advisory Committee is a powerful mechanism to keep a focus on patient outcomes. [It is] a rigorous committee and actually has held the health service to account on a few things.” (Board member, regional)</p> <p>“The feedback through our Victorian Patient Satisfaction Monitor has been that people would like written information and we’ve really tried hard to bring that in.” (Board member, rural)</p>

experience. Another chair spoke about the benefits of having consumer representatives equipped with the skills and confidence to engage effectively at a governance level rather than being perceived as spokespeople for “single issues”. (Chair, metro)

Reliable measures of both patient experience and health service performance were keenly sought by interviewees from eight boards. Such measures were described as serving a two-way function: informing boards about patient experience and informing consumers about the performance of the health service. One measure, the Victorian Patient Satisfaction Monitor, was widely used but was seen as somewhat limited in its scope. To develop a better suite of patient experience indicators, one board had actively engaged community representatives in a process of

identifying appropriate patient outcome measures. The Chair of that board’s Quality Committee explained: “community participation in our services is high and the community reps have had a direct input into the quality issues that we’re monitoring and assessing.” (Quality Chair, regional)

An openness and willingness to share information with consumers and communities was identified by some interviewees as an important enabler of good governance in this area. One board member commented: “There’s nothing held back because nothing needs to be held back” (Chair, regional), meaning that the community had ready access to information on board activities and the performance of the health service. Another noted: “We’re very into open

disclosure; keeping communication open to the person and their family.” (Quality Chair, regional)

Finally, highly engaged boards described a heightened responsiveness to consumer feedback, whether via complaints, patient surveys, service reviews, or committees. One board member commented: “We've got a community advisory committee who have a strong influence and we do take on board what their recommendations are and they have a lot of input into anything to do with the organisation.” (Chair, regional)

## Discussion

This study found that while some health service boards had high aspirations and clear plans for improving patient experience, others remained sluggish or even cynically resistant to change. Five recommendations emerged for organisations and executives to strengthen board engagement in this area: strong leaders willing to champion patient experience in the board room, commitment to openness and transparency in consumer engagement, tailored training to both board members and consumer representatives, accountability and responsiveness to consumer recommendations, and provision of performance measures to board members and consumers.

Our study has several strengths and limitations. Three strengths of this study were the high rate of participation in both the survey and the interviews, the diversity of health services involved, and their apparent candour. Board members are a difficult population to reach for research purposes, due to busy schedules and the confidential nature of boardroom discussions,<sup>32</sup> so research such as this offers a valuable glimpse into the nature of board decision-making.

With respect to study limitations, there are socially desirable responses to many of the questions we posed and we could not test the veracity of responses. This may have introduced some biases in the direction of more positive attitudes toward the value of patient experience to governance and exaggerated levels of activity in this area. In addition, differences in the statutory responsibilities and structural make-up of healthcare boards may limit the generalizability of our findings to other jurisdictions outside Victoria.

To our knowledge this is the first study in Australia to explore the attitudes and activities of health service board members towards improving patient experience. However, to the extent our study posed questions that overlapped with those posed in two previous studies undertaken in the United Kingdom<sup>19</sup> and the United States, there are a number of consistent findings.<sup>33</sup> For example, boards in those countries were also found to vary widely in their levels of engagement in activities relating to patient experience.

Our findings raise questions about health service boards' willingness and ability to adapt their priorities in response to newly emerging issues in quality and safety. While there was broad agreement among boards about the growing focus on patient experience, many interviewees expressed a sense of being swept along by changes, rather than leading the way.

Our findings also point to a gap between what is increasingly expected of boards' involvement in patient experience, and their skill and motivation to meet these expectations. Addressing these deficiencies will require careful attention to boards' training needs and the incentives for capable and patient-focused directors to apply for such roles.

For boards with a positive attitude and low activities, a gentle nudge and some practical support may be all that is required for them to become more active in this area. This support could take the form of board training,<sup>34</sup> dissemination of tools and templates, and connection with local consumer advocates. For example, in the United Kingdom, Dr. Foster Intelligence has produced a practical resource - The Intelligent Board series - that focuses on what boards can do to ensure they have a rounded understanding of how patients and their families experience care.<sup>35</sup> To the extent that boards perceive budgetary constraints as a blocking factor, further evidence on the cost and quality implications of improving patient experience may be beneficial.

For boards that are active, but unenthusiastic, the missing element is a core belief in the value of patient experience for the health services and communities they serve. Personally listening to the stories of patients or families who have suffered harm in their organisation - as recommended by the Institute for Healthcare Improvement's 'Getting Boards on Board' program<sup>6</sup> - may help these board members to put their hearts, as well as minds, into improving patient experience.

For those few boards that are both unenthusiastic and relatively inactive, it is difficult to envision any substantial moves without a change in leadership, the appearance of an influential and persuasive champion of patient experience, or externally-imposed regulatory requirements. The introduction of national standards for partnering with consumers may have an effect. As demand among community members for a better patient experience increases, the reputational and operational risks for these out-of-step boards may also increase.

Finally, the approaches taken by “positive attitude, high activity” boards could be showcased as exemplars for others. This would help to “widen the bright spot”<sup>36</sup> of high performance and would provide valuable reinforcement for leaders in the area.



Further research should explore three key areas. First, what training or practice innovations (such as presentations by consumers to the board) have the greatest effect on board attitudes and activities? Investigating the life-cycle of attitudinal change in a board that changed from disinterested and inactive to enthusiastic and active would be particularly interesting.

Second, what impact do board activities in this area have on patient experiences on the ground within the organisation? The distance between board decision-making and quality of care delivered at the bedside is a perennial challenge for clinical governance research. Although the link is more direct and should be more palpable for this particular strand of governance, determining the strength of the connection remains an important research priority.

And finally, the question of what activities consumers believe boards should be engaged in regarding patient experience remains to be further explored. To assume that enthusiastic boards or health departments know what consumers want and need, or that patients everywhere want the same things, is risky footing on which to approach the enterprise.

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### Competing interests

None

### Ethics approval

The study was approved by the Human Research Ethics Committee at the University of Melbourne.

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