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The characteristics of effective governance of healthcare quality in Australian public hospitals

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Abstract

Patients are sometimes harmed in the course of receiving hospital care. Increased awareness of harm and a board's ultimate responsibility for healthcare quality have focussed attention on processes of governance. Research in this field, through cross-sectional surveys undertaken mainly in the US, has found variable engagement in a limited set of governance processes. Survey evidence indicates a positive association between boards more engaged in these healthcare quality processes and healthcare quality outcomes, but is unable to explain variable engagement. Emerging research has begun to illuminate a number of factors, such as communication and trust, mediating engagement in healthcare governance.

This thesis builds on existing research to investigate the characteristics of effective governance of healthcare quality in Australian public hospitals. Through a comparative case study of eight hospital networks in Australia this thesis investigates both how board members and managers work together to govern healthcare quality, and factors that influence engagement in that work. A conceptual framework is developed to guide the empirical investigation. This framework, mapping commonalities between governance and related team literatures, outlines taskwork, input and teamwork constructs influencing governance

The empirical evidence presented in this thesis provides a more comprehensive understanding of healthcare quality governance processes than previously described in the literature. A range of factors influencing engagement are identified through comparing and contrasting cases with different levels of taskwork engagement. Most framework constructs are found to influence engagement in taskwork processes, however, several modifications and additions are made to constructs. These changes are reflected in the revised framework, the Healthcare Governance Performance Framework (HGPF).

The HGPF brings together, for the first time, a comprehensive range of factors influencing the effective governance of healthcare quality, some of which have received little attention in the literature to date. These factors are found to interact in complex

and unique patterns at each case. The HGPF provides a sound basis for undertaking theory-led research in healthcare governance.

This study finds effective corporate governance of healthcare quality is characterised by board members and managers who are engaged, focussed, vigilant and reflective. The results of the study highlight the need for investment in board member and management skill development, healthcare quality governance guidelines, healthcare quality data and evidence.

Declaration

This is to certify that

(i) The thesis comprises only my original work towards the PhD, except where indicated in the preface;

(ii) Due acknowledgement has been made in the text to all other materials used,

(iii) The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed

Alison Brown

Preface

My interest in healthcare governance stems from my experience as a board member, clinician, quality manager, and more recently, work assisting boards and managers of healthcare services to strengthen governance. These various roles within the healthcare industry have afforded me the opportunity to experience healthcare governance from several perspectives. I remember vividly my first time as a new member of a governing body of a not-for-profit organisation. With experience in the sector but little experience or understanding of governance, I attended my first meeting with only fleeting preparation. It was many meetings before I began to understand my role.

Over the years I have watched others grapple with the theory, practice and art of governance. Governance in the healthcare sector comes with its own set of challenges related to the technical nature of healthcare services, the difficulty in measuring healthcare quality and the lack of training and experience in governance, quality improvement and data analysis among both board members and staff. While there is an abundance of normative governance literature, this is often derived from other sectors and does not necessarily reflect the particular challenges associated with healthcare governance. I come to this study with a view that healthcare governance is unique, complex and challenging but ultimately valuable and that governance participants will benefit from a deeper understanding of the range of factors influencing its effectiveness.

Within this thesis I have included one published first author paper (with two co-authors) as a substantial element of Chapter 3. This is consistent with thesis requirements in the University of Melbourne Graduate Research Training Policy. Text on pages 29-30 and 32-45 is from the published paper *Governing the quality and safety of healthcare: A conceptual framework.* I was the initiator and main author, of the published paper contributing over 90% of the work. I undertook the literature search, analysis and writing of drafts and editing in response to reviewers' comments. My co-authors provided assistance with the editing of drafts. I have provided authorisation forms from each co-author.

The publication is attached as Appendix 8

Acknowledgments

The ability to undertake this PhD is an enormous privilege for which I am very grateful. Spending time investigating questions I have pondered in my work role was made possible by financial support in the form of an Australian Government Research Training Program Stipend Scholarship.

I would like to express my heartfelt thanks to my supervisors, Professor Margaret Kelaher and Associate Professor Helen Dickinson, who have given generously of their wisdom and expertise to guide me with care and humour in this endeavour. I have learnt much under their guidance.

I am indebted to the board members and executive staff of hospitals who, with trust and great enthusiasm, allowed me to explore their work in this study. I hope they find this research of value in addressing some of their questions.

I could not have undertaken this PhD without the love and support of my partner, Howard and son, Sam, who have patiently waited out the three and a half years I have focused on this work. Thanks also go to my extended family, especially Clay, Ali and Neddy, and to my friends who have been there when I needed to get away from study for a while. A special thank you to Annie Lanham for your support.

One of the highlights of this PhD has been the opportunity to meet so many wonderful people within the School of Population and Global Health and beyond. Thanks especially to Lila and Jade for your friendship and laughter. Grateful thanks to Myra Hoad who has provided patient guidance through every administrative stage of this process.

Finally, this thesis is dedicated in loving memory of my mother, Mary Brown, my father, Professor Roger Brown, and my brother Andrew. And in recognition of my great, great Aunt Mary Elizabeth Brown, one of the first two women graduates of the University of Sydney, who paved the way to university for many Australian women.

Abbreviations

AIHW Australian Institute of Health and Welfare

BQC Board Quality Committee

CEO Chief Executive Officer

DQ Director of Quality

DMS Director of Medical Services

DoN Director of Nursing

EM Executive Manager

HGPF Healthcare Governance Performance Framework

IMOI Input Mediator Output Input

IPO Input Output Process

KPI Key Performance Indicator

KSA Knowledge, Skills and Abilities

LHN Local Hospital Network

MQ Manager of Quality

NED Non-Executive Director

NHS National Health Service

TOR Terms of Reference

US United States

VQC Victorian Quality Council

Table of Contents

List of Tables

List of Figures

List of Boxes

Chapter 1 Introduction

> *Patients are the heart of the health and hospital system, its reason for existence. When the safety and quality of that system fails, it is patients (and their families) who suffer.... Patients and families need to have complete confidence in not only the safety but the adequate governance of ... health systems.*
>
> *(Health Issues Centre, 2016, p. 5 &12)*

This chapter presents the background and rationale for undertaking this study. The research aim and questions arising from gaps in understanding healthcare governance processes and influences on engagement in those processes are presented. Key concepts informing the study setting and context are outlined. This chapter concludes with an overview of the thesis structure.

1.1 Background to the study

Australians enjoy access to a comprehensive range of healthcare services provided through both public and private systems. Most users of Australian hospitals, in seeking assistance with their acute health needs, take for granted the quality of services they receive. This faith is generally well founded as Australian healthcare ranks highly when measured against other broadly comparable developed countries (Schneider, 2017). However, evidence of preventable harm associated with hospital care is increasingly coming to the attention of the public.

In 2015, the headline " 'Catastrophic event': Bacchus Marsh hospital investigated over seven 'avoidable' baby deaths" was displayed across the front page of *The Age* newspaper in Victoria, Australia (Butt, Hall, & Dobbin, 2015). A subsequent investigation found multiple problems at many levels within and beyond the organisation contributed to the newborn deaths (Australian Commission on Safety and Quality in Health Care, 2015; Wallace, 2015). The hospital board and CEO were subsequently dismissed. This headline echoes other reports of high profile failures in acute healthcare in other Australian states and internationally. The extent of iatrogenic harm in acute hospitals has been clarified through studies investigating avoidable

complications and harm with estimates varying from 10-16 percent of hospital admissions (Travaglia, Debono, Spigelman, & Braithwaite, 2011).

Variability in hospital quality is evident through high profile failures and from hospital level measures of clinical processes and patient outcomes (Baker, Denis, Pomey, & MacIntosh-Murray, 2010; Dixon-Woods et al., 2013; Mannion, Freeman, Millar, & Davies, 2016; Duckett, Jorm, Danks, & Moran, 2018). Reviews of hospital quality failures have indicated, as with the Bacchus Marsh hospital, a range of factors contributing to preventable patient harm. A common factor identified across reviews is the failure of boards and senior management in overseeing and responding to issues with healthcare quality in their hospitals (Hindle, Braithwaite, Travaglia, & Iedema, 2006; Francis, 2013b).

A board is a group of people charged with the legal and constitutional responsibility for governing an organisation, or corporate governance (Governance Institute of Australia, 2016). Boards vary in the number and composition of executive directors, or managers, and non-executive directors (NEDs), who are externally appointed or elected. Boards are led by a board chair who is generally a non-executive member, with the exception of some US organisations where a CEO/chair dual role exists. In addition to responsibilities for oversight of finances, strategy and CEO performance, healthcare boards have ultimate responsibility for the quality of healthcare services provided by their organisation.

1.2 Research gaps and study rationale

Research has increasingly turned toward understanding the contribution of corporate governance to the variability observed in healthcare quality in the acute sector. There has been a tendency in the broader governance literature to investigate corporate governance effectiveness through factors that are perceived to be controllable at the organisational or regulatory level, e.g. through examining board skills or board composition (Edwards & Clough, 2005; Roberts, McNulty, & Stiles, 2005). This reflects a linear mechanistic input-output conceptualisation of governance. This is a limited view of corporate governance for two main reasons. Firstly, the need to explore the influence of internal processes and dynamics on governance is identified in several studies (see for example Pye & Pettigrew, 2005; Roberts et al., 2005; Cornforth, 2012). The relative

lack of understanding of these mediators has been described as the 'black box' (Pettigrew, 1992, p. 178) of governance. Secondly, corporate governance cannot be seen in isolation from the setting within which it occurs (Nicholson & Kiel, 2007; Cornforth, 2012) . Broad social, cultural and political factors influence the shape and conduct of governance as can be seen in the different form and function of corporate governance structures around the world. Recognising that governance is a complex phenomenon provides an opportunity to reflect on a broad range of interacting factors within and beyond the organisation, some of which have received little attention to date. Broader governance literature highlights the need to address both contextual factors and a range of internal factors influencing healthcare governance effectiveness.

Healthcare governance research has begun to explore the black box through examining internal governance processes. A significant focus of research has been on the level of board engagement with a range of healthcare quality activities. Research, undertaken mainly through quantitative analysis of survey data, has highlighted variable board engagement in quality activities (see for example (Baker et al., 2010; Prybil et al., 2010; Bismark, Biggar, Crock, Morris, & Studdert, 2014). Board engagement has been assessed through a focus on a limited number of quality activities, such as the use of dashboards for quality reporting (Vaughn et al., 2006; Jiang, Lockee, Bass, & Fraser, 2009; Jha & Epstein, 2010; Jiang, Lockee, & Fraser, 2012) or the adoption of an item for quality on the board agenda (Bass, & Fraser, 2008; Jha & Epstein, 2010; Jiang, Lockee, Bismark, Walter, & Studdert, 2013). These are governance activities that are easily measured and assessed through quantitative methods, the low-lying fruit of governance (Bennington, 2010). The literature review, undertaken in Chapter 2 of this thesis, highlights the need for a more detailed understanding of processes of governing healthcare quality than surveys have provided.

Existing research has demonstrated a small, but significant, positive association between various board quality activities and healthcare processes and outcomes (see for example Vaughn et al., 2006; Jiang et al., 2009; Jha & Epstein, 2010). This quantitative research highlights the importance of these internal processes but is unable to explain what is contributing to variable engagement of boards. Emerging research, using different research methods, has illuminated factors such as communication (Freeman, Millar, Mannion, & Davies, 2016), influencing governance. This thesis builds on

emerging research to undertake a detailed investigation of both internal and contextual factors influencing healthcare governance via a comparative case study using multiple research methods.

Additional limitations in the existing literature shape the scope of this study. Most empirical research is focussed predominantly on the board, and to a lesser extent the CEO, as central actors in corporate governance. However, the theoretical literature has, since the origins of corporate governance in the separation of owner and managers of organisations, expressed an interest in the relationship between boards, as owner representatives, and management, (see for example Cornforth, 2003b; Sundaramurthy & Lewis, 2003). Governance is a complicated social interaction between board members and senior managers bounded by formal conventions established in the commercial world and influenced by differentials of power and knowledge. Board members do not act alone but 'co-produce' governance activities with managers (Cornforth, 2012). Evidence of this important working relationship is beginning to emerge in healthcare governance research (see for example Weiner, Alexander, & Shortell, 1996; Tsai et al., 2015). This study, therefore, examines the work of both the board and senior managers in healthcare governance.

Lastly, most healthcare governance research to date has been conducted in the US, UK and Europe, with very little research occurring in Australia. Given the phenomenon of governance cannot by separated from the context within which it is situated this study examines healthcare governance occurring within the Australian landscape.

1.3 Aim, research questions and scope

This study aims to identify the characteristics of effective governance of healthcare quality. The specific research questions developed to address the aim are:

1. How do boards and senior managers work together in governing healthcare quality?
2. What factors promote engagement in governance tasks?

A detailed examination of a broad range of influences on effective governance of healthcare quality in Australian public hospitals, to address gaps in the literature and

inform the research questions, is undertaken in Chapters 5, 6 and 7 of this thesis. A conceptual framework has been developed to guide the exploration of governance processes and influences on engagement with those processes. The framework was generated through mapping commonalities between governance and team effectiveness literature. The resulting framework encompasses both literatures and outlines inputs, taskwork and teamwork mediating constructs influencing governance effectiveness. The framework is tested in this study and then refined in light of the empirical evidence presented.

The study limits the examination of healthcare corporate governance to the acute setting, reflecting the availability of literature and data on healthcare quality in this sector compared with community based primary healthcare services. The study of the acute sector is confined to public hospitals. Public hospital governance shares some characteristics across Australian state and territory borders, but also has some notable differences. These differences provide the opportunity to compare the influence of state-related contextual factors on governance. Private hospitals, in contrast, are often overseen by a group governance structure overseeing a network of hospitals across states and territories in Australia, which do not provide this comparative opportunity.

1.4 The setting and context for the study

The setting for the study, along with key concepts presented, are introduced here and explored in more detail in the body of the thesis.

1.4.1 Australian public hospital system

In Australia, commonwealth and state governments fund public hospitals, with state or territory governments being responsible for managing their healthcare systems and services. This has led to considerable variation in the development of public hospital governance approaches reflecting different historical and political influences in each state and territory. Commonwealth health reform in 2011 saw the creation, among a host of other reforms, of local hospital networks (LHNs) comprising single or small groups of functionally connected public hospitals and related services across Australia. LHNs are governed by boards in most, but not all, jurisdictions.

Figure 1: Number of LHNs in Australian States and Territories in 2016 (authors own)

The 2011 health reform that created boards for LHNs in most Australian jurisdictions echoes the presence of healthcare boards as the main form of corporate governance in other countries such as US, England, New Zealand and Canada.

1.4.2 Healthcare quality definitions

This study is concerned with the governance of the quality of healthcare services delivered in LHNs in Australia. Quality is an abstract concept that is constructed through agreement upon its component parts (Mitchell, 2008). While no single agreed definition for healthcare quality exists, most definitions address its multidimensional nature (Dagger, Sweeney, & Johnson, 2007).

In a seminal work on healthcare quality, Donabedian defined quality of care in terms of information about the structures, processes and outcomes of care (Donabedian, 1966). Definitions became more comprehensive over time such as the six dimensions of quality posed as aims in the US Institute of Medicine's Crossing the Quality Chasm report which included safe, patient centred, timely, effective, efficient and equitable

(Institute of Medicine, 2001). Evolution of the term 'quality' continues with more recent definitions using fewer dimensions of quality e.g. safe, clinical effectiveness and patient experience (National Quality Board, 2013).

For the purposes of this study 'quality' is defined as safe, effective, acceptable, accessible, appropriate and efficient healthcare. Accessibility of services, often viewed in terms of the timeliness or equity of access, and efficiency of services, usually measured in terms of hospital inputs or outputs, are the subject of multiple funding incentives at state and national levels. A significant amount of time and resources are dedicated at hospitals to meet standard governmental indicators and realise financial incentives related to these two dimensions of quality. Other dimensions of quality, including safety, effectiveness, appropriateness and acceptability of care, have traditionally received less attention. It is these dimensions that are therefore likely to exhibit more variation in reporting practices between hospitals and are more useful in this study.

1.4.3 Clinical governance

No contemporary examination of healthcare quality can be separated from a discussion of clinical governance. The term clinical governance, initially developed by the World Health Organisation (Travaglia et al., 2011), first came to prominence through its use in the UK in a white paper aimed at modernising the NHS and redressing the historic focus on finances highlighted through failures at the Bristol Royal Infirmary (Department of Health, 1997). Clinical governance in this context was defined as 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Scally & Donaldson, 1998, p. 62).

Clinical governance understanding has matured over time, but is still subject to confusion in the sector. While clinical governance is an essential part of boardroom responsibilities, its focus is broader than the boardroom and includes responsibilities for actors at different levels of the healthcare system including consumers, staff, managers and external bodies. This study is concerned primarily with the clinical

governance responsibilities of board and senior management, which is integral to their corporate governance responsibilities in the healthcare setting.

1.5 Significance of the study

This study of the processes of, and influences on, engagement in governing healthcare quality in Australian public hospitals contributes to existing literature in several ways. This thesis provides a more comprehensive understanding of healthcare governance processes than has been previously presented in this field. The study builds on emerging research exploring the internal workings of healthcare boards (Freeman et al., 2016; Jones et al., 2017) to identify a range of input and mediating factors that influence engagement in processes of healthcare quality governance. These empirical findings are integrated in a revised conceptual framework, the Healthcare Governance Performance Framework (HGPF). The HGPF outlines factors found to influence effective governance of healthcare quality in the Australian public hospital setting. The framework extends existing conceptual approaches (Cornforth, 2001; Murray, 2004; Huse, 2005; Chambers et al., 2012; Chambers et al., 2013) through identifying additional constructs, relevant to healthcare governance, from the teamwork literature. This is the first time a comprehensive range of factors influencing healthcare governance effectiveness, informed by literature and empirical evidence, have been brought together in a conceptual framework.

This thesis makes visible the complex interactions of factors influencing governance effectiveness. This has practical implication for hospitals and governments in the development of correspondingly sophisticated approaches to shaping governance improvement initiatives. Furthermore, the HGPF provides a basis for undertaking theory-led research in healthcare governance.

Ultimately, this study contributes both to the theoretical literature, through the development of the HGPF, and to governance policy and practice through promoting understanding of a range of influences on the work of boards and managers in governing healthcare quality.

1.6 Thesis structure

This thesis is structured in three parts. Part 1 (Chapters 2, 3 and 4) situates the study within governance and related literature and outlines the research approach and methods. Chapter 2 highlights the growing awareness of the role of hospital boards in maintaining healthcare quality derived from both reviews of hospital quality and safety failures, and empirical research. A review of current research, both in corporate governance broadly, and in the healthcare setting, identifies a gap in understanding the inner workings of governance and the factors that influence governance engagement in healthcare quality. Chapter 3 presents the theoretical argument for the construction of the conceptual framework that guides the investigation of factors influencing governance. The genesis of the framework from existing conceptual approaches and key constructs identified in the governance and teamwork literature is outlined. Commonalities between these literatures are mapped and suggest constructs that are relevant to, but not yet fully explored in healthcare governance literature. Chapter 4 outlines the rationale for the comparative case study research design. The three qualitative methods used within the case study design, document review, observation and interviews, providing a comprehensive approach to investigating healthcare governance, are then described.

Part 2 (Chapters 5, 6 and 7) presents the thesis findings in relation to the first two research questions. Chapter 5 addresses the question of how do boards and senior managers work together in governing healthcare quality and presents evidence of multiple processes related to two commonly identified tasks of healthcare governance. Cases are then differentiated on their level of engagement in these processes. Chapters 6 and 7 address the question of what factors, falling into the input and mediator categories, respectively, promote governance engagement in healthcare quality processes. Important influences are identified through comparing cases of differing engagement levels.

Part 3 (Chapters 8 and 9) contains the discussion and conclusion. Chapter 8 brings together the empirical findings in Part 2 to revise the conceptual framework and present the HGPF. Key characteristics and principles underpinning the effective governance of healthcare quality are presented. The chapter also addresses the strengths and limitations of the study. Finally, Chapter 9, concludes by outlining

practical implications of the thesis findings for hospitals and government and suggests directions for future research.

This chapter has provided an overview of the rationale for and context to investigating the work of boards and managers in governing healthcare quality in Australian public hospitals. Chapter 2 presents a review of the literature on governance and healthcare quality.

Chapter 2 Governing Healthcare Quality

> *If all hospitals lifted their safety performance to the level of the best 10 per cent of Australian hospitals, the complication rate across the nation would fall by more than a quarter (Duckett, Jorm, & Danks, 2017, p. 3)*

2.1 Introduction

This chapter reviews the body of literature relevant to governing healthcare quality. The chapter commences by outlining the extent of preventable harm associated with hospital care and the variation in care between hospitals. Evidence from high profile healthcare failures highlights the importance of effective corporate governance in maintaining healthcare quality. The chapter then addresses the origins and development of the board corporate governance model to inform a deeper understanding of historical factors shaping contemporary healthcare governance. The adoption of the board as a dominant form of corporate governance in public healthcare is described.

The chapter then reviews the current literature on healthcare quality governance and identifies the gaps in understanding that led to the development of the research questions and shaped the approach to research. This literature, while valuable in highlighting the importance of governance engagement in quality activities, provides a limited view of governance activities and is unable to explain what is contributing to the variation in engagement. An emerging body of research using qualitative methods is beginning to shine light on internal processes and dynamics influencing governance. The role of management and the influence of contextual factors on governance receive little attention in the healthcare literature and this indicates the value of extending the scope of qualitative research. The chapter concludes by highlighting the paucity of research in Australia on healthcare governance

2.2 Healthcare harm

Understanding of the level of preventable harm to hospital patients has grown over recent decades. High rates of preventable errors in healthcare have been demonstrated widely both in Australia and internationally (Wilson et al., 1995; Department of Health,

2000; Kohn, Corrigan, & Donaldson, 2000; Wilson & Van Der Weyden, 2005; Duckett et al., 2018). Braithwaite and Coiera (2010) have reported the chances of receiving appropriate care as one in two, of being harmed in hospital as 1:10, and a preventable death or major disability as 1:50. While rates of preventable harm and complications cited in the literature vary from 10 – 16% of hospital admissions, what is clear is that some hospitals perform better than others (Gautam, 2005; Travaglia et al., 2011). Attention has turned to understanding factors that may differentiate these organisations and influence better quality of care (Scally & Donaldson, 1998). High profile failures in hospital care highlight this variation in healthcare quality and provide some insight into the causes of failures.

Formal inquiries of high profile hospital safety failures have identified a range of common problems contributing to poor care from lapses in communication and teamwork to staffing and skill levels (Casali & Day, 2010). Along with these operational weaknesses a common theme emerging is failure in leadership at multiple levels, including the board, to actively monitor healthcare quality and ensure accountability on quality (Hindle et al., 2006; Francis, 2013b). The Francis inquiry was prompted by higher than expected mortality rates and public outcry at the standards of care provided at the Mid Staffordshire NHS Foundation Trust in England. The inquiry found 'appalling care for patients' (Francis, 2013a, p. 1588) was primarily related to leadership failings on the part of the trust's board. An inquiry at the Bristol Infirmary, in 2001, investigating poor outcomes after paediatric cardiac surgery found the board to be uninvolved in reviewing available information on outcomes of care (Hindle et al., 2006). Similarly, Botje provides examples of hospital boards failing to focus on and detect poor healthcare quality in Dutch hospitals (Botje, Klazinga, & Wagner, 2013). In 2015, the Djerriwarrh Health Service in Bacchus Marsh, Victoria, Australia was investigated for high perinatal death rates. An investigation found a wide range of factors contributing to seven preventable deaths including failings at the board level. A lack of reporting outcome data to the board along with the absence of a board quality committee reflected a board lacking focus on their clinical governance responsibilities (Djerriwarrh Health Services, 2014; Wallace, 2015). This hospital was rated highly based on the performance assessment made by the state health department and had successfully been accredited during the period under investigation. These reviews all point to the importance of effective board leadership in maintaining healthcare quality.

Governments internationally have introduced measures to ensure boards address their clinical governance responsibilities. For example, US hospitals are governed by a code of federal regulations that specifically mention the board role in ensuring a sophisticated quality program that reflects the organisational complexity and service profile and includes indicators related to outcomes and medical errors (42 CFR 482.21). In the UK, regulations accompanying the Health and Social Care Act 2012 have provided the regulator with the ability to initiate criminal charges if health services breach a set of fundamental healthcare quality standards (Care Quality Commission, 2014). In Australia, 2011 Commonwealth health reform saw the introduction of devolved public hospital governance to drive improvements in outcomes (Council of Australian Governments, 2011), as is discussed further in the next section. These regulatory levers have been supplemented by multiple guidance documents outlining boards' ultimate responsibility for healthcare quality (see for example Victorian Quality Council, 2003; Conway, 2008; National Quality Board, 2013). Increased awareness of the board's essential role in preventing healthcare care harm has led to a focus on improving understanding of corporate governance roles and responsibilities in the healthcare setting.

2.3 Corporate governance

Governance derives from the Latin word *gubernare* which means to steer or rule. In the contemporary healthcare context there are many entities involved with the steering or guiding of healthcare organisations, including government, boards of health services, managers of organisations and consumers, among other key stakeholders (Cornforth, 2012). This study has a focus on governance that occurs at the executive level of an organisation, or corporate governance.

2.3.1 Corporate governance origins

A useful definition of corporate governance is 'the system by which companies are directed and controlled' (Cadbury & Cadbury, 2000, p. 8). The dominant model of corporate governance around the world is for organisations to be under the direction of a board (Gevurtz, 2004). The board model of corporate governance is characterized by board directors acting together, with equal influence, to collectively make decisions about the organisation (Gevurtz, 2004). The board generally appoints and monitors the

chief executive who in turn manages the organisation. Decisions made by the board are informed and guided by information and advice provided by management.

Early versions of board governed organisations date back to companies such as the East India Company, created under Royal Charter in 17th century Europe (Gevurtz, 2004). The model evolved in the mid-19th century in the UK and US with the creation of the legal concept of corporations, organisations recognised as legal entities separate from their owners (or shareholders) and managers (McLean, 2004; Kostyuk & Braendle, 2007). Incorporation acts to limit the liability of owners or shareholder, boards and managers for responsibility for harm and losses incurred by the organisation (Kostyuk & Braendle, 2007).

The late 1980s and 90's saw a series of financial crises in large commercial corporations that shook investor confidence and set about a range of corporate governance reforms in the US and UK (Farrar, 1999; McNulty & Pettigrew, 1999). Reforms included regulations and recommendations for greater independence of directors, largely achieved through a requirement for a majority of non-executive directors (Cadbury, 1992; Bennington, 2010).

2.3.2 Public healthcare corporate governance

The use of boards as mechanisms of corporate governance in the healthcare sector has varied over time and with geography. In Australia, public hospitals with boards of directors were the dominant model of the charitable system of hospitals established in the 19th century (Philippon & Braithwaite, 2008; Palmer & Short, 2010). Over different periods of the 20th century (although mostly in the 1980s), local area-based health authorities with greater accountability to health departments were created in several states, most visibly in NSW and QLD (Philippon & Braithwaite, 2008). Victoria, which retained hospital boards, went through a brief period of partial centralisation, with metropolitan hospital networks reporting to the health department from 1995 to 2000 before being disaggregated into 12 metropolitan hospitals with their own boards (Dwyer, 2004; Ham & Timmins, 2015).

In 2011, Australian national health reform saw the establishment of local hospital networks (LHNs) comprising single or small groups of functionally connected public

hospitals. LHNs were established to 'decentralise public hospital management and increase local accountability to drive improvements in performance' (Council of Australian Governments, 2011, p. 46). Governing councils were integral to the governance arrangement for the new LHNs. However, the number of LHNs and the form of their governance structures vary between states reflecting a combination of legacy arrangements and state level negotiated reform agreements and legislation.

In Victoria, 85 LHNs, ranging in size, are governed exclusively by boards of NEDs with accountability to the Minister for all areas of governance. The impact of national health reform was minimal on Victorian hospital governance arrangement as 85 hospitals boards existed prior to the 2011 reform. In NSW, 18 LHNs, known as local health districts, are governed by boards comprising NEDs and a minority representation of local clinicians. Prior to reform NSW had eight area health services, whose CEOs were directly accountable to the department of health. 2011 health reform saw the transition from area health services, with area health advisory councils consisting of ministerially appointed directors whose chief role was to facilitate stakeholder engagement in health service planning, to the 18 LHNs with boards (Dwyer, 2004; Philippon & Braithwaite, 2008). The NSW system is slowly divesting itself of remnants of centralised control, as seen through 2017 legislative changes in appointment and accountabilities of the CEO being transferred from the ministry to the board (NSW Government, 2017). In South Australia, five LHNs were established with governing councils working in an advisory capacity to the local hospital network, with the CEO being directly accountable to the department of health. This reflects governance arrangements existing prior to 2011 health reform. South Australian governing councils have no explicit clinical governance responsibilities. The Australian experience is an example of where a seemingly isomorphic private sector model of board corporate governance becoming heterogeneous when introduced in different state political and historical contexts (Kirkpatrick, Bullinger, Lega, & Dent, 2013). The influence of contextual factors in modifying the shape of corporate governance is apparent.

The adoption of the board model of corporate governance is seen in public healthcare organisations internationally. In the UK, both NHS trusts and Foundation Trusts have board structures, although the form differs between the two with the latter being more autonomous organisations with two-tiered governor and board structures. Boards of

NHS trusts have a mix of executive and non-executive directors. In New Zealand, public health services are managed by district health boards comprising either locally elected or ministerially appointed non-executive directors (Barnett et al., 2009). In the US, the unitary board model is dominant with CEOs usually participating as voting members of hospital boards (Prybil et al., 2008).

The rise, or in some cases re-emergence, of the board can be viewed as part of a broader trend in public management that aims to decentralise public sector accountability and responsibility to the organisation level (Hood, 1995). The assumption behind this trend is that locally governed organisations can be more responsive to patient needs through locally appropriate innovation (Veronesi, Kirkpatrick, & Altanlar, 2015). Decentralisation also aims to improve organisations 'local accountability' (Council of Australian Governments, 2011, p. 46). Although some argue that this is a weak form of decentralisation since downward accountability to local populations is limited (perhaps with the exception of the governor structure of NHS foundation trusts) and the dominant relationship is up to government and funders (Mitchell & Bossert, 2010).

The translation of a private sector model of corporate governance to public sector healthcare has been associated with a focus on financial and efficiency accountabilities. The growing volume of guidance (Chambers, Harvey, Mannion, Bond, & Marshall, 2013) and literature(Millar, Freeman, & Mannion, 2015) on the board's role in healthcare settings indicate efforts to tailor this model to a new context and ensure boards address their clinical governance role.

2.3.3 Role of the board

Corporate governance literature presents several theories to explain the board role, derived largely from examining the for-profit sector. Agency theory, prominent in this literature, highlights the potential for self-interested behaviours by managers (agents) and the need for boards to distrust and to hold managers to account through audit and performance reporting (Chambers et al., 2013). In agency theory, detached directors scrutinise the decisions and actions of senior managers within the organisation. Agency theory argues that a greater number of outside/independent directors will benefit corporate performance through the objectivity they bring in assessing management performance. However, critiques of agency theory see the reduction of management

motivation to self-interest as overly simplistic (Daily, Dalton, & Cannella, 2003). The ability of a board to effectively monitor managers can be limited by information asymmetries existing between the two groups. Similarly, attempts to equate independent directors, who can hold management to account, with non-executive or outside directors may be unreliable. Independence may be more a mindset than a characteristic intrinsic to non-executive directors (Bennington, 2010, p. 316). Studies examining the link between board composition and organisational performance have failed to provide convincing evidence to support agency theory (Roberts et al., 2005; Nicholson & Kiel, 2007).

Stewardship theory, in contrast, views the motivations of boards and managers as aligned in working together for the organisation. Managers are trusted and seen as stewards of the organisation who understand the business and can contribute to effective decision-making (Nicholson & Kiel, 2007). Knowledgeable management insiders work with outside directors to enhance strategy formulation and organisational performance (Sundaramurthy & Lewis, 2003; Chambers & Cornforth, 2010). Stewardship theory preferences greater numbers of managers or executive directors on the board. Critiques of stewardship theory highlight the potential for governance failure through closer board and management relationships fostering group think, and consensus seeking which minimises deliberations (Chambers et al., 2013).

Several other board theories exist, including managerial hegemony, resource dependency theory and stakeholder theory. Managerial hegemony argues the dominance of management, with the board acting symbolically to rubber stamp decisions made by management (Cornforth, 2004; Hendry & Kiel, 2004). Resource dependency theory sees boards seeking resources and influence through external relationships (Stiles, 2001). Board composition is diverse and determined by the important links board members can bring to leveraging resources (Cornforth, 2004). Stakeholder theory is built on the premise that boards are responsible to their broader stakeholders, holding diverse interests. This leads to the inclusion of stakeholder representatives on the board to broaden and balance views brought to the board table (Cornforth, 2004).

Agency, stewardship and managerial hegemony board theories provide varying perspectives on the nature of the relationship between board members and management in the conduct of governance. These theories are particularly useful in informing the analysis of the work of the board and management in governance in this study.

Single theories appear to hold true to aspects of hospital board practice. For example, boards have a role in monitoring organisational performance (Ostrower & Stone, 2006; Zona & Zattoni, 2007; Lee, Alexander, Wang, Margolin, & Combes, 2008) consistent with agency theory. Boards can also be seen to work with management to develop strategy as predicted through stewardship theory (Cornforth, 2012). The need for productive relationships with funders (resource dependency theory) and requirements for the composition of the board, in some jurisdictions, to reflect community, service users, or staff (stakeholder theory) are also relevant to Australian public hospital governance.

Critics argue that a single theory, such as agency theory, cannot adequately describe all board activities (Pye & Pettigrew, 2005; Roberts et al., 2005). Pursuing any single approach has its limitations and a theoretically pluralistic approach is useful in understanding the complexity of governance (Roberts et al., 2005). For example, agency and stewardship theory represent tensions between control and collaboration, but are not mutually exclusive. Sundaramurphy and Lewis (2003) argue that in practice most boards will have a combination of the two approaches. The agility of a governing body to switch and adapt modes according to the requirements of the task at hand may be critical to successful governance.

Frameworks have been developed to integrate and build on the insights provided by board role theories (Bennington, 2010; Chambers, Benson, Boyd, & Girling, 2012). These frameworks have addressed the work of boards through, for example, Garratt (1997) describing board tasks of conformance (with external requirements and though internal monitoring) and performance (through policy development and strategy) or Chait et al (2005) outlining fiduciary (oversight of assets), strategic and generative (leadership) aspects of governance. General board role theories and frameworks have addressed broad compositional considerations and task requirements, potentially influencing the

function of boards. However, they do not adequately inform an understanding of specific healthcare governance responsibilities as they do not take into account the heterogeneous settings and contexts within which governance is undertaken (Cornforth, 2012). The responsibilities of healthcare boards in governing healthcare quality are unique to this setting.

2.3.4 Board healthcare quality responsibilities

While descriptions of general board responsibilities vary, those commonly cited in the literature include setting strategy, assessing organisational performance, and stakeholder engagement (Ostrower & Stone, 2006; Zona & Zattoni, 2007; Lee et al., 2008; Chambers, 2012). It is more difficult to find detailed guidance on board responsibilities in relation to governing healthcare quality in the peer-reviewed literature. Board responsibilities are often described broadly in terms of 'developing appropriate organisational strategies, incentives and cultures to support the delivery of quality and safety' (Millar et al., 2015, p. 1) and 'ensur[ing] high quality care' (Goeschel, Wachter, & Pronovost, 2010, p. 172). Some authors, implicitly or explicitly, reference an agency perspective of governance and discuss the role in terms of quality oversight (Jha & Epstein, 2010) or accountability (Jiang et al., 2012). Detailed articulation of specific healthcare quality responsibilities is more commonly found in normative literature. More commonly referred to responsibilities include:

- Evaluating and improving healthcare quality performance (Conway, 2008; Baker et al., 2010; Jiang et al., 2012; National Advisory Group on the Safety of Patients in England, 2013; Steward, 2014; State of Victoria, 2017)
- Setting and oversight of strategic quality priorities (Vaughn et al., 2006; Conway, 2008; Machell, Gough, & Steward, 2009; Baker et al., 2010; Jha & Epstein, 2010; Jiang et al., 2012; Dixon-Woods et al., 2013; National Advisory Group on the Safety of Patients in England, 2013; Steward, 2014; Mannion et al., 2015; State of Victoria, 2017)
- Promoting leadership and culture (Conway, 2008; Steward, 2014; Australian Commission on Safety and Quality in Health Care, 2017; Leggat & Balding, 2017; State of Victoria, 2017)
- Ensuring effective systems and processes are in place to maintain and improve quality (Braithwaite & Travaglia, 2008; Baker et al., 2010; "Health Services Act,"

1988 (Vic); Australian Commission on Safety and Quality in Health Care, 2017; Leggat & Balding, 2017; State of Victoria, 2017).

Board responsibilities in governing healthcare quality broadly echo general governance responsibilities of performance monitoring and strategy development. However, it is evident that sources focus on different responsibilities, perhaps echoing the array of governance theories that inform understanding of board roles and responsibilities, rather than detailed empirical evidence of how boards enact their clinical governance role.

2.4 Healthcare governance evidence

While a large body of governance literature has accumulated over many years, there has been less focus on healthcare governance. With the increasing recognition of the role and ultimate responsibility of boards for healthcare quality over the last two decades, there has been a rapid growth in literature investigating the features of effective healthcare governance (Millar, Mannion, Freeman, & Davies, 2013). Healthcare governance research has its foundations in the vast theoretical and empirical governance literatures that predate it and can be divided into two main areas: input and mediator research. Research focusing on antecedent factors such as board member composition and board structure can be referred to as input research. Mediator research has a focus on the internal dynamics and processes at the board level. An overview of literature in these two areas is provided in this section to highlight gaps in the literature which have informed the development of this study. Emerging research is shown to be beginning to address some of these gaps.

2.4.1 Input research

The broader governance literature has had a strong emphasis on inputs, through examining relationships between board structures and organisational performance. Research has examined relationships between counts of board size, number of executive vs non-executive directors and dual CEO/chair roles, and various measures of organisational financial performance (Dalton, Daily, Ellstrand, & Johnson, 1998; Leblanc, 2004; Edwards & Clough, 2005). This has partly reflected the focus on agency theory with its implications for the need to maximise the number of independent directors on boards to effectively hold managers to account. It may also reflect the

relative ease of collecting data regarding structural features of boards and financial performance from publicly available data. Despite this focus, evidence of the impact of inputs, such as board size and composition on performance, is unconvincing and contradictory (Dalton et al., 1998; Cornforth, 2001; Roberts et al., 2005; Chambers et al., 2013).

The healthcare governance literature has explored the influence of inputs, but with an emphasis on examining relevant skills brought to the governance of healthcare quality. It is argued that clinicians on boards bring in depth understanding of quality and safety issues that increases board effectiveness (Veronesi, Kirkpatrick, & Vallascas, 2014; Chambers et al., 2018) . Research has been undertaken either through examining clinician numbers on boards or asking board members to self-rate their competencies in quality and safety. Studies have found a significant association between clinician board numbers and hospital performance in indicators of processes and outcomes of care (Jiang et al., 2009), ratings of quality (Veronesi, Kirkpatrick, & Vallascas, 2013) and, patient experience ratings (Veronesi et al., 2015). Higher rating of board member quality skills and competencies were found to be positively associated with staff attitudes to quality (Mannion et al., 2017), outcomes of care (Jha & Epstein, 2010) and hospital clinical quality performance (Jha & Epstein, 2013).

Critiques of linear approaches to understanding governance, in terms of antecedent structural factors in causal relationships to organisational performance, have argued the need for a different research approach. Researchers have suggested a greater focus on complex mediating factors, processes and dynamics, using different research methods that may influence governance effectiveness (Pettigrew, 1992; Edwards & Clough, 2005; Pye & Pettigrew, 2005; Roberts et al., 2005; Bennington, 2010; Cornforth, 2012; Chambers et al., 2013). The lack of understanding of the internal workings and dynamics of the board has been described as the 'black box' of governance (Pettigrew, 1992, p. 178).

2.4.2 Mediator research

Empirical healthcare governance research, while addressing inputs, has also begun to examine board engagement in mediating governance processes and activities. Studies

have demonstrated variable engagement of boards in healthcare governance activities including:

- time spent discussing quality (Joshi & Hines, 2006; Jiang et al., 2008; Baker et al., 2010; Prybil et al., 2010; Bismark et al., 2013; Jha & Epstein, 2013)
- placing an item for quality or quality performance on the board agenda (Jiang et al., 2008; Jha & Epstein, 2010; Bismark et al., 2013)
- formal adoption of core measures of quality (Kroch et al., 2006; Prybil et al., 2010)
- regular board monitoring of quality measures (Vaughn et al., 2006; Jiang et al., 2008; Jha & Epstein, 2010; Prybil et al., 2010; Jha & Epstein, 2013)
- establishing strategic goals for quality improvement (Jiang et al., 2008; Jha & Epstein, 2010; Bismark et al., 2013)
- setting objective measures for quality in the CEO's performance review (Jiang et al., 2008; Jha & Epstein, 2010; Jha & Epstein, 2013; Mannion et al., 2015).

The empirical literature further demonstrates evidence of a generally small but significant positive association of measures of healthcare quality and board engagement in the following areas:

- greater time spent discussing quality at the board (Jha & Epstein, 2010; Jha & Epstein, 2013; Vaughn et al., 2006)
- the existence of a board committee for quality (Jha & Epstein, 2010; Jiang et al., 2009; Jiang et al., 2012; Prybil et al., 2010)
- objective measures for quality present in the CEO's performance review (Jha & Epstein, 2010; Jiang et al., 2009)
- board review quality performance measures using dashboards or balanced scorecards (Jha & Epstein, 2010; Jiang et al., 2009; Jiang et al., 2012; Vaughn et al., 2006).

Much of the literature on board engagement in quality processes and associations with healthcare quality derives from cross-sectional surveys carried out in the US. The dominant quantitative approach to the study of boards extends from a strong tradition in related, but more established, fields of organisational psychology and leadership

(Parry, Mumford, Bower, & Watts, 2014). While this research approach has been valuable in highlighting the importance of board engagement in governance processes, there are several limitations associated with the use of surveys. Survey data is unable to explain the reasons for variable board engagement. Demonstrating a statistical association between various board practices and processes and patient outcomes measures does not establish a causal relationship. Governance is a complex social phenomenon that cannot be separated from the organisational and broader external social, historical and political context within which it is situated. It is likely that there are multiple confounding influences on governance engagement, arising from within and beyond the organisation, that have not yet been fully described in the literature to date. This gap in understanding informed the development of the second research question, to understand and identify factors influencing engagement.

A second major survey limitation is that summary descriptions of governance processes and activities used do not adequately reflect the detailed inner working of governance. For example, a survey statement such as 'board meetings have a specific item on the agenda devoted to quality' (Jiang et al., 2008, p. 127) can encompass a broad range of practices. A board with an agenda item for quality may simply note the minutes of the board quality committee (BQC) in contrast with another board that may review comprehensive information on the status of quality and updates on current quality initiatives. Survey questions, by their very nature, reduce complex tasks to simple statements. Baker et al (2010), in assessing governance activities in relation to establishing strategic quality goals, showed that while most boards had formally established strategic priorities for quality (reflecting a common survey question) only some had translated these into goals with specific targets. This indicates that each key responsibility or governance task involves several important processes that need to be undertaken to ensure effective task implementation. In the case of the task of oversight of strategic quality priorities, this involves processes of identifying a priority area, formal board endorsement, developing specific targets to measure progress and finally reviewing progress. This gap in understanding governance processes informed the first research question examining the work of healthcare quality governance.

Several additional limitations of survey methods for examining governance are evident. Many healthcare governance surveys have relied heavily on eliciting the perspective of a

single respondent (see for example (Vaughn et al., 2006; Tsai et al., 2015), often the CEO (see for example (Jiang et al., 2008; Szekendi et al., 2015) or a board member (see for example (Baker et al., 2010; Prybil et al., 2010; Jha & Epstein, 2010; Jha & Epstein, 2013) . Several authors have identified the challenge of single survey respondents in providing a sufficiently representative view in organisational research (Daily et al., 2003; Balloun, Barrett, & Weinstein, 2011). Surveys often focus on the activities of the board, rather than consider the broader activities of the senior management team, who may be important in influencing board engagement. Finally, most board survey research is undertaken in the US and findings reflect the US hospital structure and legislative arrangements. This raises questions as to the generalisability of findings to other contexts.

A number of authors have identified the need for further healthcare research using different methods aimed at illuminating the dynamics and processes of governance (Chambers et al., 2013; Millar et al., 2013; Freeman et al., 2016). Qualitative approaches are well suited to exploring real-life complex phenomenon (Bradley, Curry, & Devers, 2007; Easton, 2010). Longitudinal and case study designs have been proposed as alternative research approaches that would be useful in uncovering contributing factors and exploring governance processes in greater depth (Ostrower & Stone, 2006; Cornforth, 2012) . These research approaches are explored further in Chapter 4.

2.4.3 Emerging qualitative research

Alternatives to cross-sectional survey methods are emerging in healthcare governance research. This research is beginning to address the gaps in understanding the processes and influences on healthcare quality governance. In detailed case studies of the performance of four UK NHS boards, Freeman et al (2016) found considerable variation in the processes of framing and interpreting quality data at the governance level. The case studies all involved boards that appeared to be highly engaged with quality, based on common measures of engagement used in previous international research, yet the cases were found to differ considerably in local governance processes and in the way they framed the analysis of poor performance (Freeman et al., 2016). Similar emerging research, outlined in Table 1, demonstrates the value of qualitative research methods in providing a more detailed understanding of healthcare governance.

Article	Aims	Methods	Findings summary
(Dixon-Woods et al., 2013)	Examine culture, behaviour and engagement with quality in NHS organisations; including at the governance level	Mixed methods research programme involving sub studies which included governance interviews and document review, in a large number of NHS primary and acute organisations	Found organisations needed explicit goals for quality but this task was made difficult by a range of competing priorities Boards need a range of quantitative and qualitative data to inform problem sensing behaviour
(Bismark & Studdert, 2014)	Describe board engagement with healthcare quality issues and identify factors influencing boards' activities	Interviewed 35 board members and executives of public health services in Victoria, Australia	Identified need for benchmarking data to inform board member understanding of relative performance on quality need for board member skill development
(Freeman et al., 2016)	Examine how board members discharge their accountabilities for patient safety	Non-participant observation of four NHS hospital Foundation Trust boards in England	Differences between case studies in the framing and interpretation of infection control data
(Jones et al., 2017)	Examine how governance of quality improvement is enacted by boards	Multiple case study of 15 UK healthcare organisations (the majority of which were acute hospitals)	Boards with higher engagement in healthcare quality improvement processes: prioritised quality improvement, invested in long term internal priorities; used data to inform improvement, engaged broadly with staff and patients and had effective clinical board members
(Leggat & Balding, 2017)	Explore the impact of organisational quality systems on healthcare quality	Focus groups were conducted with 353 managers, clinical staff and board members in eight Victorian health services	Gap found between stated board and executive aspirations for quality and safety and the implementation of these. Identified, among other processes, the need for boards to hold management to account for the effective implementation of quality strategy
(Lee, Baeza, & Fulop, 2018)	Examine whether and how hospital boards use patient feedback	Interviews with board members and managers, board meeting observation and governance document review at two NHS foundation trusts	Boards used qualitative and quantitative patient feedback to develop strategies, set targets for quality improvement and design specific quality improvement initiatives but used this data less for subsequent monitor strategies or provide assurance on healthcare quality.

Table 1: Emerging research of healthcare governance processes and dynamics

Research described in this section highlights the value of qualitative methods in bringing a more nuanced understanding of internal governance processes and dynamics. For example, these studies indicate the approach to evaluating healthcare quality at the board needs to be informed by a broader approach to data selection than indicated in the focus on reviewing dashboards in surveys (Dixon-Woods et al., 2013; Bismark et al., 2014) . Freeman et al (2016), further highlight the influence of governance dynamics in the framing of information that is presented to the board. This study intends to build on this emerging qualitative research to contribute to a more comprehensive understanding of healthcare governance.

2.5 Gaps in the literature

Two main gaps in understanding, identified in the review of extant healthcare governance literature in the previous section, include the lack of detailed understanding of processes of healthcare quality governance and influences on engagement in these processes. These gaps informed the development of the research questions. The review of the extant literature highlights several additional gaps in the literature. These include the lack of focus on the management role in governance, the influence of contextual factors on board engagement and understanding healthcare governance in the Australian context. These gaps are explored in this section and have shaped the scope of inquiry.

2.5.1 Role of management

Much of the empirical healthcare governance literature has a limited view of the actors involved in governance, namely board members. Cornforth (2012) highlights the limitations of equating governance solely with boards and points to the broader governance systems that exist within and external to an organisation. While this study is restricted to a focus on corporate governance, the scope of inquiry is broader than that of just board members. The relationship between board and senior management has long been of interest in the theoretical corporate governance literature (as outlined in 2.3.3). Governance requires both board and management to contribute and interact in the execution of sometimes complex tasks (Cornforth, 2012).

There is some evidence emerging of the link between board and managers in governing healthcare quality. Weiner, Alexander, & Shortell (1996), in an analysis of a survey conducted in over 2000 hospitals in the US, found that CEO involvement in healthcare quality activity increased board activity in processes of governing healthcare quality. Tsai et al (2015) found boards that were more engaged in quality and demonstrated effective use of board level quality measures were significantly positively associated with management more engaged in practices of monitoring healthcare quality data and setting targets. The authors of this study note that it is not clear whether it is management driving the board's performance or the other way round. The other possibility is that boards and managers influence each other's performance. Botje et al, in a study of 155 European hospitals, found that stronger quality management systems and processes were associated with more frequent discussion of quality performance at the board level (Botje et al., 2014). These studies provide early evidence of the interrelatedness of quality healthcare activities of board and senior management.

Further research highlights that it is not just the activity of board and management that is important in healthcare governance, but also the relationship dynamics. In investigating the role of the board and management collaborating on the development of hospital strategy, Buechner et al (2014) asked questions related to communication, cooperation, length of decision-making and board involvement in operational decision-making and found a significant relationship between the quality of board management collaboration and hospital financial and efficiency performance. The study by Freeman et al, described above, demonstrates variation in practices of governing healthcare quality were influenced by board and management dynamics (Freeman et al., 2016).

These studies indicate the value of the broader scope of this thesis, to include senior management, in order to further explore the influence of management on corporate governance engagement.

2.5.2 Contextual influences

Extant research has a focus on factors influencing governance engagement that are amenable to change within organisations with a relative neglect of factors beyond the organisation that can shape governance engagement. Researchers have drawn attention to the need to broaden the scope of inquiry to consider contextual factors influencing

governance (Murray, 2004; Cornforth, 2012). Cornforth describes boards as sitting at the boundary of organisations, concerned with both the inner workings of the organisation and at the same time looking outwards to ensure accountability and compliance with external requirements (Cornforth, 2003a). Boards are, therefore, subject to influences arising externally and from within the organisation.

There are a multitude of contextual factors that potentially influence governance engagement in healthcare quality. Vaughn (2006), in a survey of hospital quality leadership undertaken in 413 US hospitals, identified the influence of external government and regulatory agencies, consumers and accrediting bodies on the selection of quality priorities. Dixon-Woods et al, found that the range and diversity of externally-set quality priorities operating on health services impede the development of clear unifying organisational objectives for quality (Dixon-Woods et al., 2013). Belmont, outlines US regulatory and accreditation frameworks that ensure a more active role of board in healthcare quality (Belmont et al., 2011). In contrast, Bismark et al identified the negative effect of multiple Australian regulatory and accreditation requirements in creating a governance burden in need of rationalisation (Bismark & Studdert, 2014). The importance of factors external to the organisation, but whose influence on governance is specific to the particular context within which they are situated, is evident from this literature.

Contextual factors addressed in the studies described are not exhaustive and little attention has been paid to broader social and cultural factors on governance engagement. There is a need for comparative studies of corporate governance to further identify and investigate the influence of contextual factors on governance engagement. This study addresses contextual factors as part of the exploration of factors influencing engagement in governance tasks.

2.5.3 Australian healthcare governance

Healthcare governance research has largely been undertaken in the US with a growing literature from the UK. A gap exists in understanding healthcare governance in the Australian context. Tregoning (2000) and Wilson et al (1993) studied the characteristics of hospital boards nationally and in rural WA respectively. Few empirical investigations of the role of board in governing healthcare quality in Australia have been undertaken.

The work of Bismark et al (2013) is an exception here. The authors investigated public health service board attitudes and activities in relation to quality of care in Victorian public hospitals and found variable board engagement in quality activities. In a related study Bismark et al (2014) identified a range of perceived barriers to engagement. Leggat and Balding (2017) further examined the role of board leadership of healthcare quality, as part of a broader study on organisational quality systems, and found a gap between the aspirations and implementation of healthcare governance. Research on the role of corporate governance in improving healthcare quality in Australia is nascent. This study builds on this existing literature to further explore influences on healthcare governance in the Australian context.

2.6 Chapter 2 Summary

Boards are the dominant form of corporate governance widely seen in public sector healthcare organisations in Australia and internationally. Increasing concern over healthcare safety and quality has led to a greater focus on the responsibilities and activities of the board in relation to clinical governance. Quantitative research has highlighted variable board engagement in healthcare quality activities and provided evidence of a positive association with quality activities and outcomes. However, there is a limited understanding of healthcare governance processes and what is driving variable engagement in these processes.

This literature review highlights the opportunity to build on cross-sectional survey data to first, understand in greater detail the processes of healthcare quality governance and second, investigate the influences on effective engagement in these processes. The research approach builds on emerging qualitative studies that allow in-depth exploration of, not only, the inner workings of governance but the contextual factors that shape governance. The importance of expanding the scope of board research to include senior management who interact closely with the board on healthcare governance activities has been identified. The limited number of studies on healthcare governance in Australia indicate the value of adding to this literature. The literature review provides the rationale for exploring the work of boards and senior managers in governing healthcare quality, and input and mediating factors influencing their engagement in that work, in Australia.

Chapter 3 explores the theoretical approach to undertaking a detailed investigation of the complex social phenomena of healthcare governance undertaken by boards and senior management.

Chapter 3 A Guiding Framework

3.1 Introduction

This chapter presents the conceptual framework used in this study to guide the detailed exploration of the work of, and influences on, healthcare governance. This chapter begins by outlining the utility of a conceptual framework to guide empirical examination of healthcare governance. Contradictions in existing governance frameworks are resolved through the development of a new framework. The new framework builds on constructs influencing effectiveness identified in the governance literature and incorporates insights from a well-developed framework in a related field of team theory. The chapter then describes the method by which team and governance literatures were reviewed to inform the framework development.

The commonalities between governance and team effectiveness literatures are mapped and suggest a number of constructs in the team effectiveness literature are applicable to, but not yet fully explored, within the governance literature. The mapping process highlights gaps in healthcare governance research related to board dynamics and external influences that require further investigation. The chapter concludes by presenting the conceptual framework, encompassing both literatures, that outlines input and mediating factors influencing governance, used to guide the empirical stage of the study.

3.2 Using frameworks in theory-led research

A conceptual framework has been described as a representation of 'interlinked concepts that together provide a comprehensive understanding of a phenomenon' (Jabareen, 2009, p. 51). Conceptual frameworks can guide the selection of constructs or factors of interest and assist in focusing an examination of a complex phenomenon (Maxwell, 2013).

A range of conceptual frameworks for exploring factors influencing governance effectiveness may be found in the literature (Cornforth, 2001; Murray, 2004; Huse, 2005; Chambers et al., 2012; Chambers et al., 2013). In one of the most widely known contributions in this field, Cornforth (2001) proposed and tested an input, structure and process, and output categorisation of key constructs for board performance in the not-

for-profit sector. This conceptualisation proposed that inputs, such as board member skills and experience, and processes such as role understanding, meeting practices and review processes, explained most of the variation in effective execution of governance tasks. Huse (2005), building on the work of Roberts et al (2005), presents a conceptual framework that expands on these internal processes and includes constructs such as trust, cohesiveness, criticality and highlights the importance of behavioral aspects of governance in mediating task performance. In a review of healthcare governance literature, Chambers et al (2012) outlines a categorisation of three key board elements relating to composition, focus and dynamics. These frameworks highlight both commonalities encountered in construct categorisation in the literature, as seen in grouping board member characteristics, as well as differences noted in factors seen to influence internal governance dynamics.

The emphasis on different factors in existing frameworks can be addressed through developing a new conceptual tool that builds on the strengths of existing frameworks, while at the same time bringing new perspectives informed by other fields and emerging healthcare governance research. Governance research, highlighting factors related to board inputs, dynamics and processes, bears striking similarities with the team effectiveness literature. The team literature derives from a vast body of research in psychology, organisational theory and management. Therefore, the starting point for developing a new conceptual framework in this thesis is through referencing the well-developed team literature.

3.3 The board and management team

The work of board directors acting collectively has previously been compared with that of a team in a number of studies (Forbes & Milliken, 1999; Sundaramurthy & Lewis, 2003; Payne, Benson, & Finegold, 2009; Harrison, Murray, & Cornforth, 2012; Prybil, Bardach, & Fardo, 2014). Similarly, the collaborative activity of managers and boards can be described as teamwork (Conger & Lawler, 2009; Kay & Goldspink, 2015).

While a multitude of definitions for teams exist, most share the concept of an identifiable membership who work together to fulfil commonly held goals. Hoegl et al, define a team as a 'social system of three or more people, which is embedded in an organization (context), whose members perceive themselves as such and are perceived

as members by others (identity), and who collaborate on a common task (teamwork)' (Hoegl & Gemuenden, 2001, p. 436).

Types of teams are differentiated in the literature based on variables such as membership, longevity, frequency of teamwork, purpose and level of authority and/or decision-making autonomy. Team types include those that:

- Produce goods and services such as work teams (Cohen & Bailey, 1997)
- Comprise managers (Cohen & Bailey, 1997)
- Are short-term in nature, working on specific projects (Cohen & Bailey, 1997)
- Are made up of representatives from across the organisation with different functions and skills to work on quality improvement and problem solving, such as parallel teams (Cohen & Bailey, 1997) or cross-functional teams (West, 2012).

Boards and quality committees represent forms of combined board and management teams. Boards have a defined stable membership of formally appointed members and attending managers who meet regularly to work on defined tasks. Board committees, made up of selected board members and managers, are routinely established to assist and inform the work of the board. BQCs have elements that align with the composition and function of a cross functional or parallel team. Parallel teams are used for problem solving and quality improvement and are given limited autonomy that requires recommendations to be made higher in the organisation (Cohen & Bailey, 1997).

A possible critique of viewing the work of board and management in governing healthcare quality as that of teamwork is in the formal accountability requirements of management to board that are integral to governance. Management requirements to report to the board may inhibit the collaborative working relationship with the board, as argued through the lens of agency theory (Chambers et al., 2013). However, in this thesis it is argued that boards and quality committee have the commonly cited characteristics of teams. Relationships of hierarchy and accountability among participants of board and quality committees are therefore viewed as a particular feature of governance teams that may place additional pressures on teamwork. How well these accountability tensions are managed may influence the effectiveness of governance teams.

Most empirical research on team effectiveness has been conducted on work teams, with less research on parallel or cross-functional teams (Cohen & Bailey, 1997). Many tools developed for operationalising research in healthcare teams reflect this focus and are designed for groups of people with similar clinical skills or with different professional backgrounds but working on a defined group of patients (Valentine, Nembhard, & Edmondson, 2015). To develop a framework to guide empirical investigation of board and management work it was necessary to return to the team effectiveness literature to understand how key constructs may be applied in the healthcare governance context.

3.4 Team theory

The theoretical literature examining teams, although vast, is reasonably consistent in organising key constructs influencing effectiveness according to categories based on inputs which are transformed through intermediate processes into outputs of teams (Kozlowski & Ilgen, 2006; Mathieu, Maynard, Rapp, & Gilson, 2008). An early input, process and output (IPO) model of team effectiveness, developed in the 1960s, has been adapted over time to reflect a greater understanding of the range of variables influencing team effectiveness, interactions between variables and a broader interpretation of outputs (Kozlowski & Ilgen, 2006; Mathieu et al., 2008). Subsequent models share mostly similar key constructs, but can vary in allocating these to categories and in portraying interactions between categories (Marks, Mathieu, & Zaccaro, 2001; Mickan & Rodger, 2005; Senior & Swailes, 2007).

The Input-Mediator-Output-Input (IMOI) model, presented in Figure 2, has been chosen as the basis for developing a healthcare governance framework. There are two main reasons for choosing this model. Firstly, the IMOI model is a useful team effectiveness model in portraying the non-linear relationship and cyclical interplay between variables over time (Ilgen, Hollenbeck, Johnson, & Jundt, 2005). Secondly, processes of teams are represented as a range of teamwork mediators comprising behavioural processes involving actions or interactions between team members, and emergent states that are attitudes, motivations or thought processes (Marks et al., 2001). Refining intermediary variables in the IMOI model into emergent states and behavioural processes provides a useful model for separating out processes of

governance from affective and cognitive states that arise as board members and managers interact. The model indicates how these may, in turn, influence each other and the outputs of governance.

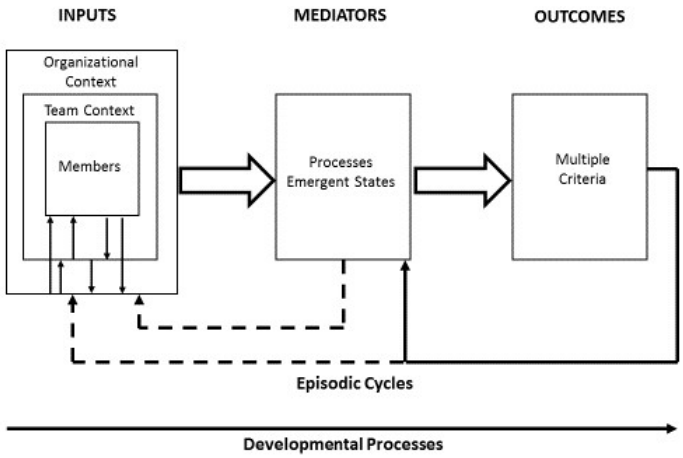

Figure 2: IMOI model from Mathieu (2008)

The purpose of using team theory is to provide a starting point to develop a new conceptual framework. Referencing a well-developed conceptual framework in a related field to develop a new framework is in line with previous conceptual research (Wendt, Frisina, & Rothgang, 2009; Nuckols, Escarce, & Asch, 2013). However, limitations exist in using team theory, even the more agile IMOI model, to represent the complex phenomenon of healthcare governance. Critiques of the dominance of mechanistic approaches, such as team theory, to improving healthcare quality have emerged over the last few years (Braithwaite, 2006; Waring, Allen, Braithwaite, & Sandall, 2016). Waring et al (2016) acknowledge the contribution of these approaches to knowledge of organisational level factors but argue that a sociological lens can illuminate a broader range of social, political and cultural factors that may be important in healthcare but have received scant attention to date. This highlights the danger inherent in thinking that a simple modification to a few organisational factors, through a linear mechanistic

approach to problem solving, would result in improved governance. The new framework addresses the limitations of its more mechanistic origins through making visible the multiple and multilevel factors that influence healthcare governance effectiveness.

3.5 Developing a new conceptual framework

The first step in developing the conceptual framework involved a comprehensive review of team literature to identify commonly cited constructs related to the broad categories presented in the IMOI model. For example, while trust is also described in the team literature as 'efficacy', 'potency' and 'safety', the term 'trust' and 'safety' were the most commonly used forms. A literature search was conducted of English language papers from 1990 onwards using electronic databases Medline/PubMed and Google Scholar and hand searches of reference lists of relevant papers. Once key team constructs were identified, subsequent literature searches were undertaken to locate the occurrence of team constructs in healthcare governance literature. The search categories and specific terms used are presented in Table 2.

Category	Search Term
Teams	"Team*" OR "Team effectiveness"
Team Constructs	"Outcome" OR "Performance" OR "organi?ational performance" OR "Measurement" OR "Monitor*" OR "Quality indicators"
	"Strateg*" OR "Priorit*" OR "Goal*" OR "Objective*"
	"Knowledge" OR "Skill*"
	"Composition"
	"Purpose" OR "Shared Objective*" OR "Shared Goal*"
	"Leader*"
	"Communication"
	"Decision Making"
	"Trust OR "Safety"
	"Cohesion" OR "Respect"
	"Conflict" OR "Conflict management"
Governance	"Board*" OR "Govern*" OR "Trustee" OR "Director" OR "Governing Board"
Healthcare	"Hospital" OR "Health care" OR "Delivery of health care"
Quality and Safety	"Quality and safety" OR "Patient safety" OR "Quality improvement" OR "Clinical governance" OR "Quality of health care"

Table 2: Categories and search terms used in literature searches

Tables 3 and 4 in the following sections indicate the results of the search related to each team construct in the input and mediator categories respectively. The degree to which constructs have been considered within the healthcare literature is also summarised in these tables, according to a categorisation based on the volume of sources that feature this construct, as outlined in the legend accompanying tables. While not assessing the quality of the studies, this approach highlights some current gaps in healthcare governance research. The result of this mapping is described below and includes suggested modifications to the IMOI model in developing a framework relevant for healthcare governance research.

3.5.1 Inputs

The IMOI model outlines multiple inputs at individual, team and organisational level that may influence team effectiveness. An individual level input is the knowledge, skills and abilities (KSAs) of individual team members. KSAs are described as either technical, related to task execution, or teamwork, such as conflict management and communication skills (Stevens & Campion, 1994; Senior & Swailes, 2007). Team level inputs in the literature include constructs such as team composition (Cohen & Bailey, 1997; Edmondson, 1999), development of a purpose (Edmondson, 1999; Mickan & Rodger, 2005; Porter-O'Grady, 2015) and power or autonomy (Payne et al., 2009; Aime, Humphrey, Derue, & Paul, 2014). The approach to understanding context as an input focuses mostly on resources available at the organisational level such as, availability of suitable information from varying sources and perspectives, time to work on team activities, and provision of incentives (Senior & Swailes, 2007; Payne et al., 2009). While the importance of the external context has been noted by team researchers more broadly (Cohen & Bailey, 1997; Mathieu et al., 2008; Payne et al., 2009) its articulation in team effectiveness models is not always apparent.

Many team effectiveness input constructs were found in the review of healthcare governance literature. Low levels of formal training in technical skills of quality improvement have been found at the board level (see for example Jiang et al., 2008; Jha & Epstein, 2010). The Keogh review of low performing NHS trusts identified limited available skills in data analysis as a barrier to governance oversight (Keogh, 2013).

Technical knowledge and skills have been shown to have a positive impact on board effectiveness (Payne et al., 2009). In clinical teams, technical KSAs are monitored through systems of credentialling or developed through ongoing mandatory professional development schemes. Conflict management, leadership and effective communication are teamwork KSAs identified in the broader governance literature (Gautam, 2005; Buechner et al., 2014; Freeman et al., 2016). The existence, or development of, teamwork KSAs that support effective governance have received little attention in healthcare literature to date.

Governance research has historically had a strong focus on the composition of boards, which aligns with team level inputs, as discussed in Chapter 2. Board composition research has failed to convincingly find a strong association between factors such as size, demographics, diversity and tenure of members, and financial performance (Nicholson & Kiel, 2007; Chambers et al., 2013). Edwards and Clough (2005) suggest that these factors may be important in providing the right environment or minimum standards for governance, but are not in themselves sufficient for good performance. Others argue that the influence of compositional inputs may be context specific (Chambers, 2012), for example, board clinical representation can influence quality of care (Prybil, 2006; Jiang et al., 2009). A more recent study found this to be the case, only when combined with other organisational-related structural input factors such as organisational autonomy (Veronesi et al., 2015).

Inputs articulated in the team literature move beyond compositional considerations, to an exploration of factors not readily addressed in the healthcare governance literature. A team needs a clear purpose which can drive development of specific objectives (West, 2012). While there has been considerable focus in healthcare governance research on activities of the board, there is little understanding of the clarity of purpose behind these activities.

The healthcare governance literature has touched on organisational-level inputs through examining information made available to the board to perform its duties (see for example Jiang et al., 2009; Jha & Epstein, 2013; Mannion et al., 2015). However, broader external influences on healthcare governance effectiveness need further investigation, as discussed in Chapter 2. The influence of external factors on healthcare

governance can be seen both in the existence of other forms of governance and in variations in corporate governance structures that exist in public healthcare in countries such as the UK, USA, Australia and NZ. These countries vary in the number of executives included as formal board members, which may have implications for the way in which boards relate to, and work with, their management team. The clarity with which the board's role in governing healthcare quality is expressed in legislation and regulatory mechanisms may also influence understanding of purpose and role perceptions at the board. The influence of broader socio-cultural factors on governance has been included as an external input. Sociocultural influences, in this study, refer to differences in groups of people based on gender, class or culture. The healthcare governance literature has not yet considered socio-cultural influences. The external context as an input has been added to the healthcare governance framework to reflect the influence of the broader social and political environment at this level of governance.

A summary of key inputs arising in the team literature and the volume of papers from the healthcare governance literature review that address each construct is presented in Table 3.

Input Level	Construct in the healthcare governance literature	Volume of papers with construct in literature reviewed
Individual	Technical knowledge skills and abilities (quality improvement and data analysis) (Jiang et al., 2008; Baker et al., 2010; Jha & Epstein, 2010; Goeschel, Berenholtz, Culbertson, Jin, & Pronovost, 2011; Keogh, 2013; Millar et al., 2013; Bismark et al., 2014; Millar et al., 2015; Szekendi et al., 2015)	+++
	Teamwork knowledge skills and abilities	+
Team/Corporate Governance	Board composition (Molinari, Morlock, Alexander, & Lyles, 1993; Prybil, 2006; Jiang et al., 2009; Chambers, 2012; Veronesi et al., 2013; Veronesi et al., 2015)	+++
	Defined Purpose (Chambers et al., 2013; Millar et al., 2013)	+
	Power/Autonomy (Abbott, Smith, Procter, & Iacovou, 2008; Alexander, Lee, Wang, & Margolin, 2009; Jones, Lankshear, & Kelly, 2016)	++
Organisation	Resources (Baker et al., 2010; Bismark & Studdert, 2014; Vaughn et al., 2014)	++
	Information/Data available (Gautam, 2005; Jiang et al., 2008; Jiang et al., 2009; Baker et al., 2010;	+++

	Goeschel et al., 2010; Belmont et al., 2011; Goeschel et al., 2011; Bismark et al., 2013; Botje et al., 2013; Jha & Epstein, 2013; Millar et al., 2013; Bismark & Studdert, 2014; Mannion et al., 2015; Millar et al., 2015; Szekendi et al., 2015)	
External	Legislation and regulation (Gautam, 2005; Goeschel et al., 2010; Belmont et al., 2011)	++
	Accreditation(Gautam, 2005; Vaughn et al., 2006; Jiang et al., 2008; Jiang et al., 2009; Baker et al., 2010; Belmont et al., 2011; Bismark & Studdert, 2014)	+++
	Sociocultural influences	+

+++ Considerable volume of literature (more than 6 peer reviewed papers)
++ Several journal articles (3 or more peer reviewed papers)
+ Little or no known literature

Table 3: Key input constructs in the healthcare governance literature review

3.5.2 Mediators

In early conceptualisations of team theory, mediating processes were described as comprising taskwork and teamwork processes (Mathieu et al., 2008). Taskwork describes the actions a team must undertake to achieve team tasks, 'the what', and teamwork describes the interactions between team members, 'the how' (Marks et al., 2001). Teamwork is seen as guiding the execution of taskwork through 'direct(ing), align(ing) and monitor(ing) taskwork' (Marks et al., 2001, p. 357). Yet, much contemporary team literature and conceptual models, such as the IMOI model, are focussed on teamwork processes with less analysis of the concept of taskwork. This may be because taskwork is varied and specific to the team and context under study.

According to the IMOI model, understanding teamwork requires consideration of both behavioural processes and emergent states. Analysing behavioural processes, the actions or interactions between team members, involves concepts such as leadership, decision-making, communication and conflict management (Marks et al., 2001). The influence of emergent states on effectiveness requires exploration of attitudes, motivations or thought processes. Emergent states can be either affective, such as developing trust, cohesion and conflict, or cognitive such as developing shared role understanding and goals (Marks et al., 2001; Millward & Jeffries, 2001; Mickan & Rodger, 2005; Jelphs & Dickinson, 2008; Strating & Nieboer, 2009). These last two mediators are

particularly important in work comprised of more cognitive tasks, such as governance, which involve planning, design and decision-making (Cooke, Salas, Cannon-Bowers, & Stout, 2000). Recent healthcare governance literature illustrates these teamwork mediators. Freeman et al (2016), found, through measures of engagement used in previous international research, that all boards appeared to be highly engaged with quality yet had considerable differences in the way analysis of poor performance was framed. The authors found that data on poor performance was either framed as unreliable data, associated with an unreasonable target or an event requiring investigation. Similarly, Keogh's (2013) review of low performing NHS trusts identified the tendency to use information for justification, rather than for enquiring into areas of concern.

The framing of a quality issue is an aspect of communication and appears to be an important behavioural process influencing healthcare governance effectiveness and may reflect the level of trust that exists. A key task in healthcare governance is for management to reveal operational areas that require improvement. The need for high levels of trust, an affective state, between board and management to enable full and open discussion regarding quality issues has been highlighted in the recent healthcare governance literature (Chambers, 2012; Millar et al., 2015). Reduced trust may lead individuals to resist any revelations that may be interpreted as weaknesses. These constructs influencing healthcare governance fit into behavioral processes and affective emergent states mediators suggested in team literature.

The degree to which board members and managers have developed a shared understanding of their respective roles and their shared work objectives has received little attention in the healthcare governance literature and may be an important cognitive mediator of effectiveness.

The IMOI model does not address activities and tasks of teams as a mediating process. Evidence presented in Chapter 2 demonstrated variable board engagement in healthcare governance tasks and provided evidence that governance taskwork is positively associated with healthcare outcomes. Engagement in taskwork is an important mediating influence of healthcare governance effectiveness.

Adding taskwork as a mediator of governance effectiveness in the conceptual framework requires examination of detailed processes related to each key healthcare quality task. Much of the empirical literature examining key tasks in governing healthcare quality has used broad measures of taskwork to study board engagement. The task of evaluating healthcare quality is often presented as a survey question probing the use of quality dashboards or scorecards (Vaughn et al., 2006; Jha & Epstein, 2010). Yet it is clear there is more to evaluating quality. The Francis report arising from the inquiry at Mid-Staffordshire Hospital, makes clear the distinction between having healthcare quality data available and translating this data into knowledge that supports a clear understanding. Report recommendations include the need for appropriate metrics with norms established to allow identification of poor performance (Francis, 2013b).

The task of evaluating healthcare quality can, for example, be broken down into key mediating processes such as:

- Developing an agreed measurable definition of healthcare quality (Hundert & Topp, 2003; Heenan, Khan, & Binkley, 2010).
- Board endorsement of quality measures (Kroch et al., 2006; Prybil et al., 2010; Prybil et al., 2014)
- Developing a quality reporting framework with agreement on format, frequency and reporting responsibilities (Vaughn et al., 2006; Levey et al., 2007; Jiang et al., 2008; Baker et al., 2010; Jha & Epstein, 2010).
- Regular reporting of performance (Prybil et al., 2008; Jha & Epstein, 2010; Jiang et al., 2012; Mannion et al., 2015)
- Trending and benchmarking performance (Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012)
- Identifying areas for improvement with corrective action plans identifying responsibilities and timelines (Kroch et al., 2006; Prybil et al., 2010)
- Reporting on progress of corrective actions in relation to serious issues and incidents (Jiang et al., 2008; Baker et al., 2010)
- Periodic review of quality monitoring framework (Joshi & Hines, 2006; Australian Commission on Safety and Quality in Health Care, 2011).

In this way, a detailed examination can be made of the extent to which all the processes related to each key task in governing healthcare quality are undertaken. Key tasks, in addition to evaluating healthcare quality, include oversight of quality priorities and planning (Vaughn et al., 2006; Baker et al., 2010; Jha & Epstein, 2010; Dixon-Woods et al., 2013; Mannion et al., 2015), leadership of a quality culture (Weiner, Shortell, & Alexander, 1997; Conway, 2008) and the resourcing and oversight of key quality systems such as credentialing and incident management (Braithwaite & Travaglia, 2008).

Adding the taskwork category to the proposed framework, reflecting current evidence in the healthcare governance literature, provides a comprehensive basis for exploring interactions of inputs, taskwork and teamwork mediators on governance effectiveness. Table 4 below maps the volume of papers in which mediator constructs in team theory were found in healthcare governance literature. Note that only two of the four identified tasks of governance of healthcare quality were included in the mapping exercise, reflecting the scope of this study.

Category of Mediator	Construct in the healthcare governance literature	Volume of papers with construct in literature reviewed
Taskwork	Monitoring quality performance (Hundert & Topp, 2003; Joshi & Hines, 2006; Kroch et al., 2006; Vaughn et al., 2006; Levey et al., 2007; Jiang et al., 2008; Prybil et al., 2008; Jiang et al., 2009; Baker et al., 2010; Heenan et al., 2010; Jha & Epstein, 2010; Prybil et al., 2010; Jiang et al., 2012; Prybil et al., 2014; Mannion et al., 2015)	+++
	Developing quality priorities (Baker et al., 2000; Mannion, Davies, & Marshall, 2005a; Joshi & Hines, 2006; Vaughn et al., 2006; Jiang et al., 2008; Machell et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012; Bismark et al., 2013; Fresko & Rubenstein, 2013)	+++
	Leading and promoting a quality culture	(not mapped)
	Resourcing and oversight of key quality systems	(not mapped)
Teamwork: Behavioural processes	Leadership (Weiner et al., 1996; McDonagh, 2006; Vaughn et al., 2006; Glickman, Baggett, Krubert, Peterson, & Schulman, 2007; Ovretveit, 2009; Jiang et al., 2012; Chambers et al., 2013; Millar et al., 2013; Buechner et al., 2014; Millar et al., 2015)	+++
	Communication (Gautam, 2005; Buechner et al., 2014; Vaughn et al., 2014; Mannion et al., 2015; Millar et al., 2015; Freeman et al., 2016; Jones et al., 2016)	+++
	Decision-making (Abbott et al., 2008; Buechner et al., 2014;	++

	Veronesi et al., 2015)	
Teamwork: Affective emergent states	Trust (Abbott et al., 2008; Baker et al., 2010; Chambers et al., 2013; Buechner et al., 2014; Millar et al., 2015; Szekendi et al., 2015)	++++
	Respect: (Baker et al., 2010)	+
	Cohesion:	+
	Conflict: (Jones et al., 2016)	+
Teamwork: Cognitive Emergent States	Shared role understanding/Role clarity (Baker et al., 2010; Veronesi & Keasey, 2011; Chambers et al., 2012; Davies, Chapman, & Boyd, 2015)	++
	Shared objectives/ goals (Mannion et al., 2015)	+
Teamwork: other descriptions	Social Dynamics (Baker et al., 2010; Millar et al., 2013; Millar et al., 2015; Veronesi et al., 2015; Freeman et al., 2016)	++

+++ Considerable volume of literature (more than 6 peer reviewed papers)
++ Several journal articles (3 or more peer reviewed papers)
+ Little or no known literature

Table 4: Key mediator constructs in the healthcare governance literature review

3.5.3 Outputs

The team effectiveness literature outlines individual, team and organisational levels at which outputs can be assessed. Individual-level outputs may be evaluated, for example, through role-based performance measures (Mathieu et al., 2008). Team-level outputs can be assessed through subjective measures of the working relationship or, objective measures of sick leave, turnover or production measures (Cohen & Bailey, 1997; Kay & Goldspink, 2015). Organisational-level evaluation is considered most relevant to teams senior in the hierarchy where there is believed to be a closer alignment between work at this level and organisational outcomes (Lemieux-Charles & McGuire, 2006; Mathieu et al., 2008).

Research evaluating healthcare governance has largely focussed on organisational outcomes measured through patient, financial and efficiency outcomes measures. However, there are often challenges in identifying an appropriate mix of robust organisational-level measures that reflect the complexity of quality outcomes in hospitals (Brook, McGlynn, & Cleary, 1996; Adair et al., 2006; Duckett, 2016). Commonly-used outcome measures, such as standardised mortality measures and

infection rates, are plagued by methodological issues that weaken their usefulness (Lilford, Mohammed, Spiegelhalter, & Thomson, 2004; Scobie, Thomson, McNeil, & Phillips, 2006; Evans, Bohensky, Cameron, & McNeil, 2011; Pronovost & Lilford, 2011). These types of measures are distant from governance activities and may be confounded by management practices and human resources issues such as workforce shortages. While patient outcomes are of ultimate interest in any strategy to improve healthcare quality, the team literature suggests additional measures that may overcome issues of access to suitable organisational-level outcome measures and their related attribution issues. The suggestion here is not to abandon outcome measures, but to add these additional measures to obtain a more sensitive reading about performance.

The team effectiveness literature draws attention to individual and team-level outputs as more proximal measure of effectiveness. Measures of teamwork quality at the governance level could be made through modifying existing team effectiveness tools that examine various teamwork constructs (Valentine et al., 2015). Measures of taskwork quality could be developed based on assessment of the presence or absence of processes related to each key governance quality task as outlined earlier. Evaluating team-level healthcare governance outcomes, could then be obtained through developing a survey of teamwork and taskwork quality. An instrument such as this could be useful both for board evaluation and education purposes and for research in examining the relationship between various healthcare governance performance constructs and proximal outputs. The team literature provides a useful basis for broadening the approach to evaluating outputs in healthcare governance.

3.6 The conceptual framework

The mapping process suggested several key constructs in the IMOI model are not yet fully explored in the healthcare governance literature. This exercise also highlighted modifications required to construct categories for use in a healthcare governance framework. The resulting conceptual framework is presented in Figure 3.

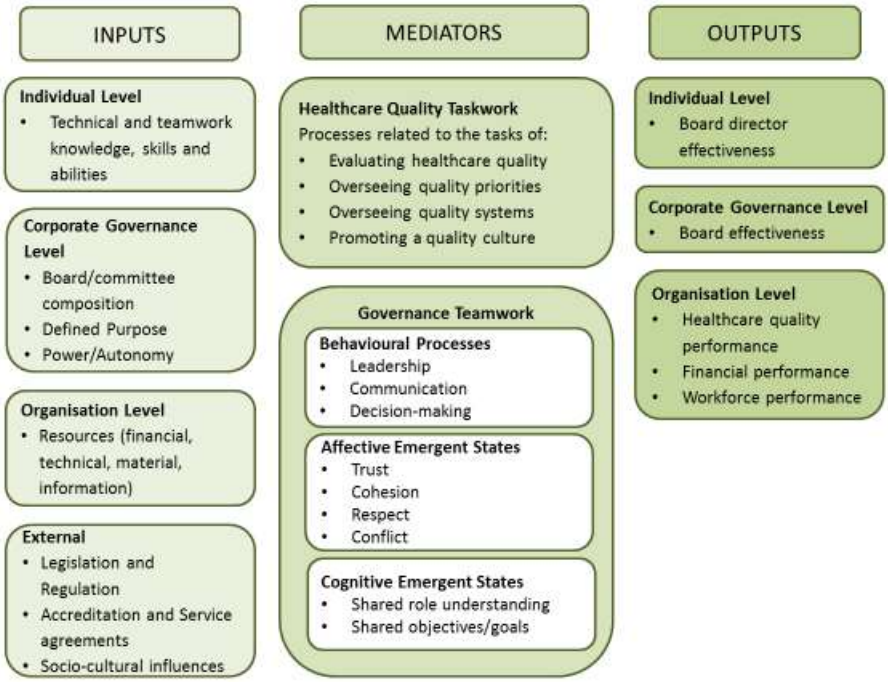

Figure 3: The conceptual framework

The emphasis placed on broader external influences as key inputs and the addition of taskwork mediators in the framework reflects evidence in healthcare literature of challenges and barriers particular to healthcare governance. The focus on board composition in the governance literature as a key input to effectiveness is reflected in the healthcare governance literature reviewed, as shown in Table 3. The importance of individual quality skills and knowledge as a key input is also well established in the healthcare governance literature (see for example Jiang et al., 2008; Payne et al., 2009; Jha & Epstein, 2010) but considered mainly in terms of board members and not in relation to senior management who work closely with the board on governance tasks. Other inputs that are relevant to defined groups of people working together on common tasks such as a clear purpose and availability of resources and information to support the work are less well researched in healthcare governance (Baker et al., 2010; Chambers et al., 2013; Millar et al., 2013; Bismark & Studdert, 2014). External influences on healthcare governance are addressed in the literature in a limited way, mainly through the lens of accreditation (see for example Baker et al., 2010; Bismark & Studdert, 2014) and to a lesser degree legislation and regulations (Goeschel et al., 2010;

Belmont et al., 2011). The broader social, political and cultural influences on healthcare governance need closer consideration.

The framework incorporates the taskwork category. The overwhelming body of healthcare quality governance research is focussed on board engagement with quality tasks that are broadly described in surveys. Chapter 2 presented the argument for a more detailed exploration of healthcare governance taskwork. Section 3.5.2, in this chapter, outlined the approach through exploring the extent to which processes related to each key quality task are undertaken. Such an approach allows a nuanced understanding of the extent of board and management engagement in quality activities. Factors influencing engagement in taskwork are then addressed through exploring input and teamwork mediating constructs in the framework.

Emerging research addresses teamwork constructs, either broadly under the heading of board dynamics (see for example Baker et al., 2010; Veronesi et al., 2015) or through specific inquiry into constructs such as trust (Chambers et al., 2013; Buechner et al., 2014) or communication (Gautam, 2005; Freeman et al., 2016). The mapping in Table 4 highlights teamwork constructs currently under-researched in the healthcare governance setting, including behavioural constructs such as leadership and decision making, affective constructs such as cohesion, conflict and respect, and cognitive constructs such as shared role understanding and shared objectives.

3.7 Chapter 3 Summary

This chapter has presented a theoretical argument for the development of a new conceptual framework to guide the investigation of healthcare governance in this study. The resulting conceptual framework builds on existing frameworks across different literatures and emerging research. The new framework draws on the mature team literature, as corporate governance work is often compared with that of teams. Team literature provides a useful conceptual model, the IMOI, for exploring factors influencing governance work. Mapping key constructs in team literature to the occurrence of these constructs in healthcare governance literature produced compelling evidence of the relevance of many of the constructs and categorisations in team literature to the healthcare governance setting. This in turn provided the theoretical

justification for using the IMOI model as a starting point for developing a new conceptual framework.

Organising multiple factors that influence the complex phenomenon of healthcare quality governance in a conceptual framework provides a mechanism for structuring theory-led research in this thesis. The framework is used to inform areas for further investigation in the empirical stage of the study, and to guide the development of data collection tools related to each research method used. Later, in the discussion chapter, the findings of the study are used to revisit and re-evaluate the framework.

The next chapter, Chapter 4, outlines in detail the research questions, the approach to the research and the research methods used in this study.

Chapter 4 Research Approach

This chapter describes the approach and methods taken in this study to address the research aim and questions (as presented in Chapter 1). The research questions address two main gaps in the literature in need of further research and ask firstly 'how board and managers undertaken the key tasks of healthcare quality governance?' and secondly 'what factors promote engagement in governance taskwork?'. The approach and methods used to develop the conceptual framework to inform the case study investigations are not addressed here as they were described in Chapter 3.

The chapter begins by describing the rationale for choosing a comparative case study design in examining healthcare governance. The purposive sampling approach in selecting contrasting cases is then detailed. This includes a discussion of the challenges experienced identifying cases on the basis of high and low performance assessed through available measures of healthcare quality performance in Australia, and the need to modify case selection methods accordingly. Processes to ensure informed consent and confidentiality undertaken prior to the recruitment of cases are then addressed. The case recruitment process is explained, and the eight cases studied in this thesis are introduced.

The rationale for the research methods selected in this study is followed by an explanation of the approach to data collection for the document review, interviews and observations undertaken. Data analysis techniques using tools developed to structure thematic analysis around constructs in the conceptual framework are outlined. The chapter concludes with a discussion of the way in which the quality and the rigour of inferences made from the data were strengthened to describe the phenomena of healthcare governance.

4.1 Research design

This section describes the rationale for the case study design, growing out of limitations in existing research approaches. The approach to the comparative case study is detailed through addressing the population of LHNs, the case selection strategy, ethical considerations and case recruitment processes.

Chapter 2 outlined a body of empirical healthcare governance research that has employed quantitative survey methods extensively. While this research has been valuable in developing an initial understanding of healthcare governance processes and their positive association with healthcare outcomes there are limitations associated with the use of surveys. Survey limitations described in Chapter 2 include the provision of summary descriptions of board processes limiting the range of responses participants can provide and the use of single respondents limiting the perspective on governance (see section 2.4.2). Surveys relying on self-reported measures can also be influenced by social desirability bias (Lavrakas, 2008) and may result in respondents providing a more positive view of governance engagement than that which they believe in order to present a favourable view of their activity.

In this thesis, the views of both board members and managers are considered essential in understanding the internal workings of governance. Answering the research questions also requires the use of different data sources and methods to provide a more complete understanding of governance processes and factors influencing engagement.

4.1.1 Comparative case study

The research questions in this thesis explore 'how' governance work is undertaken and seek to explain 'why' engagement in taskwork varies through identifying factors influencing governance taskwork. Case studies are particularly useful in addressing these exploratory 'how' and explanatory 'why' questions (Baxter, 2008; Yin, 2009; Stewart, 2012). There are two additional reasons a case study design is useful in this thesis. Firstly, a case study approach is particularly suited to an in-depth exploration of a phenomena where there are challenges in 'separating the case from the context in which it occurs' (Boblin, Ireland, Kirkpatrick, & Robertson, 2013, p. 1267). Corporate governance is firmly situated within the organisational setting and is shaped by multiple forces within and external to the organisation. Case studies facilitate both the study of organisational processes and the contexts within which they occur (Hartley, 2004; Baxter, 2008). Secondly, multiple cases allow cross-case comparison of similarities and differences to identify patterns that can support or contradict a theoretical proposition (Eisenhardt, 2002; Stewart, 2012). The comparative case study approach adopted in this thesis, allows the exploration of factors contributing to differing levels of governance engagement. The approach provides multiple opportunities to replicate

the examination of influences on governance engagement which can provide strong support for confirming the importance of various factors.

Varied approaches to undertaking case studies exist, reflecting researchers from diverse disciplines with differing ontological (nature of reality) and epistemological (nature of knowledge production) viewpoints (Harrison, Birks, Franklin, & Mills, 2017). Two methodological approaches commonly referred to in case study design are represented by Yin's post-positivist and Stakes' constructivist approach (Boblin et al., 2013). These divergent methodological stances give rise to different practices of case study research. Stakes' constructivist approach emphasises the subjective nature of reality and the need to consider and embrace the inherent bias in various perspectives encountered in the research (Boblin et al., 2013). The aim is to gather multiple and diverse accounts to understand individual and shared meaning (Crowe et al., 2011). Reality, in this approach, is understood to be specific to a context and a situation and is interpreted through the lens of the researcher (Lauckner, 2012; Harrison et al., 2017).

Post-positivist perspectives on case studies argue that, while difficult, investigation can bring the researcher closer to understanding reality (Patton, 2002). The post-positivist approach understands that measurement is subject to bias and efforts are made to minimise bias. Yin's approach to case study therefore has a focus on minimal interaction with research subjects and triangulating data from multiple sources of evidence to control bias (Crowe et al., 2011; Boblin et al., 2013; Harrison et al., 2017). Yin also outlines the benefits of using a framework to guide areas of investigation with *a priori* identification of constructs helping to target research activity. Theory can then be revised to accommodate the discovery of new elements discovered in the case study (Yin, 1999).

This study is primarily concerned with developing and testing a conceptual framework. The framework represents a theory of healthcare governance that is being tested. As such the study is undertaking theory led research exploring middle-range theory. Theory led research is characterised by the pragmatic selection of appropriate research methods (Pawson and Tilley, 1997). The choice of data collection and analysis methods are guided by the type of data needed to test the theory and the available data.

The approach to case study research adopted in this thesis is more in line with Yin's practice. Comprehensive information is collected, guided by a conceptual framework, through multiple research methods. The data from different sources is then triangulated to inform an understanding of governance processes and the working relationship of participants on the board and quality committee at each case. This comparative case study approach is in line with emerging qualitative research exploring healthcare governance undertaken by Freeman et al (2016) and Jones et al (2017). It also reflects the increasing use of a case study approach in health services research (Boblin et al., 2013) and the use of comparative case studies in governance research (Stewart, 2012).

4.1.2 Population of interest

A case is defined as 'phenomena of some sort occurring in a bounded context' (Miles & Huberman, 1994, p. 25). The case or unit of analysis in this study is corporate governance of healthcare quality occurring within LHNs. Of interest in the study are LHNs governed by boards of directors with direct responsibility and accountability for governing healthcare quality. The two territories and Tasmania were excluded from the population due to low numbers of LHNs. South Australia has governing councils with no direct responsibility or accountability to the state minister for healthcare quality and these were also excluded. Western Australia was in the process of transitioning from this model to boards in the year of data collection. At the time the study commenced, only Victoria, NSW and Queensland had LHNs governed by boards in sufficient numbers.

Victoria and NSW were selected to be the states with suitable populations of LHNs for inclusion in the study. The selection of two states allowed for the possibility of identifying and comparing contextual factors operating in different states. NSW was chosen over Queensland for practical travel reasons.

Exclusion criteria applied to the selection of LHNs in each state. The 18 NSW LHNs are broadly similar in composition, generally consisting of multisite regional networks. Victoria's 85 LHNs vary from very small single site rural hospitals to large metropolitan teaching networks. Very small hospitals commonly lack dedicated quality staff, with CEOs or Directors of Nursing (DoNs) often absorbing these roles. Given the interaction

of staff occupying dedicated quality roles with the board were of interest in this study, the smaller Victorian cases were excluded. Very small hospitals were identified as Group D hospitals in the AIHW peer groups for acute public hospitals (Australian Institute of Health and Welfare, 2015). LHNs comprising hospitals in AIHW categories larger than Group D hospitals were included in the population. Specialist hospitals such as those addressing the needs of women, children and cancer patients were also excluded from both states. The exclusion of specialist hospitals allowed more uniformity in the potential pool of information reported at the board to assist comparative analysis. One LHN from each state was excluded based on being a subsidiary of a national group hospital structure overseen by a single national board. The final population meeting the selection criteria included 35 Victorian and 15 NSW LHNs.

4.1.3 Case selection strategy

The intention of this comparative case study was to test and refine theory, or 'analytic generalisation' (Yin, 2009, p. 15). This required that cases be purposively sampled: that is, carefully selected based on their characteristics, so that each case, either provided an opportunity for confirming or contradicting theory (Yin, 2009). This approach highlights patterns of similar or contrasting results that strengthen the explanation of observed results (Tsang, 2014). Purposive case selection in this study was undertaken to both increase the likelihood of contrasting or 'polar types' (Eisenhardt, 2002, p. 12), and, extend the examination of healthcare quality governance to a broader range of public hospitals. This latter strategy broadens the potential applicability of any theoretical propositions developed to a wider group within the population identified (Eisenhardt, 2002; Tsang, 2014).

The intention was to recruit 9 hospitals, 6 from Victoria and 3 from NSW. This number was considered to provide sufficient cases to identify patterns in confirming or contrasting information and allow a sufficient depth of inquiry at each case, within the timeframe for the study. The initial sampling aim was to obtain an even number of high and low performing Victorian hospitals based on their outcomes in relation to healthcare quality. Several authors have used this approach to enable attributes of high performers to be identified through the comparison made between boards from higher

performing hospitals with boards of lower performing hospitals (Mannion, Davies, & Marshall, 2005b; Prybil, 2006; Chambers & Pryce, 2011).

Publicly available hospital quality performance data was sourced nationally and at a state level. This included data on safe, appropriate, acceptable and effective process and outcomes of care. Accessibility data, such as waiting times, and efficiency measures were seen to be less useful as they are subject to performance measures that ensure less performance variability between health services. At the time of case selection in 2015, nationally available hospital-level quality data, falling into the quality dimensions sought, was limited to *Staphylococcus aureus* infection rates and hand hygiene compliance rates, although the latter was not comparable between states (Australian Institute of Health and Welfare).

NSW and Victoria differed in publicly available state level quality data. In NSW, a range of healthcare quality process and outcome data was publicly available, including hospital acquired infection rates and state level patient experience survey data. Similar data was not publicly available in Victoria at the time. Lengthy negotiations were held with the Victorian health department regarding access to this data to inform the identification of high and low performing hospitals. Access was provided to non-identifiable hospital level data including departmental performance assessment scores, hospital standardised mortality ratio (HSMR) and in-hospital mortality for AMI, stroke, fractured neck of femur, and pneumonia to allow selection of suitable cases. However, the department later reneged on identifying coded data supplied stating that approaching health services for permission to identify them would be a 'burden for health services' (N. Reinders, Personal Communication, September 6, 2016) due to their concurrent involvement in departmental consultations reviewing healthcare post-failures at the Bacchus Marsh health service.

The revised sampling strategy, while not being able to identify high and low performers based on quality data, aimed to achieve some diversity in organisational healthcare quality performance in order to increase the likelihood of cases with differing levels of governance engagement in healthcare quality. Stratified purposive sampling was first employed, with Victorian hospitals stratified according to size and location, to ensure a mix of hospitals of different size and complexity. Hospitals that satisfied the size and

geographical requirements for selection were then considered based on their perceived quality healthcare performance obtained through expert opinion. Three experts in understanding the quality of care delivered by Victorian public hospitals were identified through discussion with key informants and asked to nominate hospitals with high and low performance in the delivery of quality healthcare. In this way a pool of hospitals varying in size, geography and perceived quality healthcare performance were identified from which to undertake recruitment. In NSW, the intention was to recruit three hospitals to provide a reasonable number of cases from which to compare state-level contextual factors operating on LHNs.

4.1.4 Informed consent and confidentiality

Ethical considerations in the conduct of this study centred on issues of informed consent and confidentiality. Cases provided confidential and sensitive information detailing patient harm and healthcare quality in board and committee documents and required assurance on methods of data storage and security. In addition to organisations giving consent to participate as case studies, individual participants were required to provide consent for interview and observation. Explaining processes for ensuring anonymity and confidentiality and the ability to withdraw interview and observation data were critical in facilitating open and frank communication. Information and consent forms emailed prior to interviews were reviewed and signed prior to the commencement of an interview (see Appendix 1). The observation plain language statement (see Appendix 2) was circulated with the agenda for the committee meeting at which the observation occurred. I also requested time at the commencement of a meeting to remind participants of the confidentiality of both the organisation and individuals involved and the ability of individuals to have their contributions deleted from observation notes taken.

4.1.5 Case recruitment

Case recruitment was undertaken through a letter to the CEO requesting participation of the LHN in the research. The letter (see Appendix 3) outlined the research approach and advised organisations that a summary report of the data collection at their case would be provided at the completion of their data collection period. Twelve Victorian LHNs were approached and six were recruited. Four NSW LHNs were approached and two were recruited. Recruitment of cases was a lengthy process that involved in-

principle approval by CEOs followed by formally submitting the request for participation to the board. At a few cases, the board requested further information or a presentation from me prior to deciding on participation. The time from initiation of the request to decision to participate varied from one to five months. In NSW, the board approval process was followed by a lengthy state level ethics approval process, and by a further site-specific ethics approval process. Given the protracted nature of recruitment in NSW, a third case was not successfully recruited within the time frame for data collection.

The final profile of organisations recruited as cases is presented in Table 5.

Case reference	State	Rural/ Metropolitan	Single site/network	LHN Revenue ($million)	Case Descriptors
C1	Vic	Metropolitan	Network	>500	Large metro Vic
C5	Vic	Metropolitan	Single hospital	>500	Large metro Vic
C3	Vic	Rural	Single hospital	50-150	Medium rural Vic
C4	Vic	Rural	Single hospital	50-150	Medium rural Vic
C6	Vic	Rural	Single hospital	<50	Small Rural Vic
C8	Vic	Rural	Single hospital	<50	Small Rural Vic
C2N	NSW	Rural	Network	>500	Large rural NSW
C7N	NSW	Metropolitan	Network	>500	Large metro NSW

Table 5: Profile of cases

Cases are referred to in this thesis by the nomenclature indicated in the case reference column of Table 5. The N included in the case reference for C2N and C7N indicates they are NSW cases.

4.2 Research methods

Within healthcare governance research there has been a growing interest in the use of qualitative methods to explore the 'black box' (Pettigrew, 1992, p. 178) of governance to gain a deeper understanding of the inner workings of governance. This reflects the increasing use of qualitative methods in the health service research area. (Bradley et al.,

2007). Qualitative research methods are suited to detailed investigation of complex phenomena and provide detailed information to deepen understanding (Parry et al., 2014). Governance is a complex phenomenon influenced by social, political, cultural, organisational and individual factors. Qualitative methods enable light to be shone on areas that quantitative research has indicated are worthy of investigation but cannot fully explore.

Case studies allow the use of multiple data sources. Using multiple research methods enables exposure to multiple perspectives and provides rich and comprehensive data (Lauckner, 2012). The researcher is able to compare and corroborate findings across different data sources to develop 'a confluence of evidence that breeds credibility, that allows us to feel confident about our observations, interpretations and conclusions' (Eisner, 2017, p. 110).

Data for case studies can be generated from quantitative or qualitative methods. The limitations of quantitative survey methods have been discussed earlier. A range of qualitative methods suitable for examining complex phenomena exist and include document review, interviews, observation, focus groups and ethnography or participant observation (Baxter, 2008). The use of focus groups is generally suited to non-controversial topics conducted among strangers where the number of question to be asked is limited (Patton, 2002). This method was not appropriate for this study given the number of questions in the interview schedule and the potentially sensitive nature of questions regarding participants' perspectives on the board management relationship. Frank and open discussion of this relationship may have been inhibited by the presence of other focus group members. Participant observation, in the form of immersive ethnographic fieldwork over a lengthy time period, while possible, was less likely to be attractive to study participants, was less congruent with the highly structured nature of governance and more difficult to conduct given the intermittent nature of board activity. The methods of interview, document review and BQC meeting observation were selected within the comparative case study design to make visible multiple forces at play in healthcare governance.

Interviews allow participants freedom to express their experience of governance without the degree of self-censorship that may occur in a focus group setting. They also

allow exploration of abstract constructs that are not easily examined through observational methods (Patton, 2002). Semi-structured interviews were used in this study to explore in detail participants' perspectives on a range of governance processes and relationship dynamics. Bias can occur when interviewees feel pressured to give answers that present their governance activities in a favourable light or suffer from poor or inaccurate recall of events (Yin, 2009). The potential for this bias was addressed through the conduct of multiple interviews at each case to get a range of perspectives on the same issues and through triangulating interview findings with other data sources (Yin, 2009).

Observations were included to provide another perspective, through my direct exposure to the spectacle of governance at the BQC meeting at each case. This method promotes an understanding of phenomena not afforded by interview or document review and allows the observer to see things participants may not be aware of (Patton, 2002). Observations provide a detailed view of meeting practices and dynamics in 'real time' (Yin, 2009, p. 102) that cannot be fully captured by minutes or second-hand descriptions. This research method was used effectively by Freeman et al (Freeman et al., 2016) in a healthcare governance setting to reveal aspects of governance processes and dynamics not previously described in the literature.

Document analysis is a research method commonly used in case studies to provide an additional source of data to corroborate evidence (Bowen, 2009; Yin, 2009). Document review has many strengths, including that documents developed prior to the research process are unaffected by observer bias. In addition, they are often comprehensive and provide a level of detail not readily available by other methods (Bowen, 2009). Documentary review was important in this thesis in gathering comprehensive information on governance processes and information reviewed at the corporate governance level. Potential issues of biased document selectivity (Yin, 2009) were overcome in this study through reviewing governance papers over a 12-month period. Reviewing board and committee papers made transparent the volume, format and complexity of information board members receive in governing healthcare quality. Other documents such as terms of reference, planning documents and quality frameworks informed a broader understanding of the context within which governance of healthcare quality was conducted within each case.

The data collection processes related to each research method and data analysis is addressed in the following two sections.

4.3 Data collection

This section addresses the data collection processes associated with each research method used in this comparative case study. Semi-structured interviews with board and management participants, corporate governance documentation review and an observation of a BQC meeting were conducted over a 2-week to 3-month period at each case. The data collection period extended from July 2016 to April 2017.

4.3.1 Document review

Key governance documents were reviewed at each case. Upon agreement to participate, LHN CEOs were sent a request for documents which included the following items:

- Board quality committee papers: Meeting papers (all papers forming documentation provided to board members for meetings) for the last 12-month period
- Board meeting papers (all non-commercially sensitive papers forming documentation for meeting) for the last 12-month period
- Organisational Chart
- Detailed Current Strategic Plan
- Board charter/terms of reference (or similar document outlining board responsibilities)
- Board annual calendar/workplan (or similar document detailing scheduled board tasks)
- Board Quality Committee terms of reference
- Board Quality Committee calendar/workplan (or similar document detailing scheduled committee tasks)
- Quality/Clinical Governance Policy or Framework (or similar document outlining the organisation's approach to a quality framework/system).

Board and committee meetings of Australian public hospitals are not generally open access and related documents are not publicly available, with the exception of NSW cases which made board minutes available on their websites. At two cases sensitivity

around the confidentiality of board papers resulted in the on-site review of governance documents and making detailed notes. At all other sites document copies were provided to me prior to the on-site visit.

Twelve months' worth of board and committee papers were reviewed to control for selectivity bias and enable a comprehensive insight into governance activity over a complete annual cycle (Bowen, 2009). Collection and analysis of documents was undertaken prior to interview to enable me to interview participants with a clearer understanding of the structures, governance processes and reporting undertaken at their organisation.

Any information considered vital to informing construct analysis at a case, which was missing due to incomplete documentation, was sought through additional requests for information or additional questions in the interviews.

4.3.2 Semi-structured interviews

Interviews were used to explore abstract framework constructs such as trust and leadership which were less easily explored through document review (Patton, 2002). Interviews enabled me to explore how participants had constructed their understanding of governance and what implication this had on their behaviours and interaction with others (Patton, 2002, p. 96). Interviews were also used to clarify input and taskwork constructs examined in the document review.

Upon formal agreement of case participation from a LHN CEO, I requested details of a contact person to organise interviews. Interviews were requested with the CEO, BQC chair and the most senior staff member responsible for healthcare quality. Cases were also asked to nominate an additional board member and clinical executive staff member, both of whom attended the BQC. Table 6 shows the profile of participants interviewed at each case. Plain language statements and consent forms were distributed to interviewees prior to the interview via the contact person.

Position	C1	C2N	C3	C4	C5	C6	C7N	C8	Total
CEO	1	1	1	1		1	1	1	**7**
BQC Chair (board member)	1	1		1	1	1	1		**6**
Board member of BQC	1	1	2	1	1	1		2	**9**
Director/Manager of quality (DQ/MQ)	1	1	1	2	1	2	1	1	**10**
Director of Nursing (DoN)					1		1		**2**
Director of Medical Services (DMS)	1		1	1				1	**4**
Director of Clinical Program Area (DC)		1							**1**
Total number of people interviewed	**5**	**5**	**5**	**6**	**4**	**5**	**4**	**5**	**39**

Table 6: Profile of interview participants

Thirty-nine people were interviewed in total across all cases. At C5, a new CEO had commenced at the organisation in the interview week and was not available. At C3 and C8, the BQC chair was not available on the day of the interview and substitute BQC board members were organised. At C7N, a board member was unavailable on the day of interview and a substitute could not be arranged. All interviews were conducted on site except for two phone interviews; a board member at C6 and a staff member at C8. Individual one-hour interviews were scheduled, except for C4 and C7N which both included one two-person interview due to requests made by these cases for this arrangement.

Semi-structured interviews were based on an interview schedule developed from constructs identified in the conceptual framework (see Appendix 4). Interviews consisted of mainly open-ended questions with one multiple choice question and two questions asking participants to rate board and committee effectiveness on a scale of 1 to 10. The choice of the largely structured open response interview format allowed brief descriptive accounts to be provided by participants to multiple areas of investigation (King, 1994). Semi-structured interviews also provided flexibility in enabling the asking of additional questions that emerged from the dialogue (DiCiccoBloom & Crabtree, 2006). This was important in clarifying and expanding on points raised by interviewees. One multiple choice question addressing communication style at the BQC was developed in order to prompt interviewees to consider key features of communication identified in the existing literature and to explain their selection. Two questions

requiring numerical ratings were used also as a mechanism for interviewees to explain their responses in detail. The semi-structured interviews were audio recorded and then transcribed by me. I listened to taped interviews after each interviewee to review interview technique and reflect and consider responses in light of any unconscious researcher bias introduced in questions.

Interviewees were allocated a unique identifier in the transcripts and are referred to in abbreviated form in this thesis. For example, interview participant 1 is referred to as IP1 and identified by their position and their organisation (i.e. IP1, CEO, C1). Board members are identified by the word 'board member' and this refers to non-executive board members, and for NSW cases this may also include clinician representatives. Management are indicated by position designations other than 'board member', e.g. CEO or DoN, On a few occasions where sensitive information is provided, such as critiques of staff or board members, the position and/or case reference will be omitted to provide further protection to the interview participant from possible identification within their organisation. Where an excerpt or an exchange is included, I will be identified by the letter 'R' for researcher and the interview participant by 'IP'.

Note that quotations from the BQC observations are distinct from interview quotations. Observation quotations are either located within the three boxes describing observations from BQC meetings in Chapter 7 or alternatively when cited in the text include the notation 'BQC observation notes'.

4.3.3 Observation

The BQC was chosen for observation as this meeting is devoted to governance oversight of healthcare quality. The focus on the BQC as the site of observation, rather than the board, is consistent with Jones et al (2017) who found that detailed scrutiny of healthcare quality occurred at BQCs. Observations were made of a single BQC meeting at each case to understand the operations and dynamics of the meeting. Meeting observations were scheduled after most interviews enabling interviewees to develop some familiarity and trust with me prior to the observation. While approaches to qualitative observation can involve varying degrees of researcher participation, the strict conventions of governance largely restricted me from being any more than an observer. The meeting observations were guided by a schedule (see Appendix 5) to

prompt the recording of observations around constructs of interest. The observations were guided by the principle of gathering thick descriptions which allow the reader to enter into the experience (Patton, 2002). Detailed notes were made regarding the following elements:

- The setting for governance which included a description of the physical environs
- The degree of involvement of the different participants in the processes of governance and cues for their involvement
- The structure and activities of the meeting
- The way in which issues or data is framed or presented at the meeting (Chong & Druckman, 2007).

Direct observation was undertaken in this study by a single researcher which limited the ability to take comprehensive notes of all events. To address this, I focussed less on the detailed contents of agenda items at the meetings, as these were generally well documented in accompanying meeting papers, and more on the recording of duration of agenda items, the involvement of various participants and the interchange that occurred through questioning of agenda items. Descriptive notes of observations were handwritten by me during the meeting and supplemented by additional notes and clarification immediately after the meeting.

4.4 Analytic strategy

The broad approach to data analysis used in this study was thematic analysis. Thematic analysis is a systematic process of identifying themes within the data (Braun & Clarke, 2006). The specific approach to thematic analysis differed between data sources.

Documentary analysis was undertaken as the initial process in data analysis at each case. The raw data was organised into document types and read by me in chronological order, where appropriate. A document review template, in the form of a word document, was used to summarise the raw data from each case (see Appendix 6). The template was based on constructs in the conceptual framework with additional contextual information. The process of document review enabled a summary of the large volume of governance documents at each case, often 4000-6000 pages, and identified findings in relation to key constructs.

Transcribed interviews were imported into NVivo software for analysis. Template analysis, a form of thematic analysis, was employed to code the interview transcripts. Template analysis involves the development of a codebook to guide the categorisation of segments of text (Brooks, McCluskey, Turley, & King, 2015). The codebook can be developed *a priori* or can emerge from the analysis of the data (King, 2004). In this thesis, a codebook was developed prior to data collection and was refined throughout the process of analysing data (Brooks et al., 2015).

Interviews were analysed using both deductive and inductive approaches. Deductive approaches to analysis rely on existing knowledge (Elo & Kyngäs, 2008). Deductive analysis starts with constructs describing the phenomena being studied in an *a priori* conceptual or theoretical framework which is then tested in the empirical phase (Pope, Ziebland, & Mays, 2000; Patton, 2002). Inductive analysis involves reflecting on data to identify emerging constructs or categories (Pope et al., 2000; Patton, 2002; Elo & Kyngäs, 2008). An inductive approach is often used when less is known about a phenomenon and the analysis then supports theory generation.

Interviews were first coded deductively in NVivo according to a codebook developed from the conceptual framework (see Appendix 7). Three interviews were initially coded to refine the codebook and clarify any definitional vagaries in the codebook. All interviews were then coded via the revised codebook. This is in line with processes for template analysis described by Brooks et al (2015). Coding of the full data set involved two stages, an initial coding followed by a review of coding decisions. Any unresolved coding was coded to a dedicated node that was later resolved by me at the completion of coding all interviews.

A second inductive and iterative coding process was applied to the initial interview analysis. Material initially coded to framework constructs was then reviewed to identify underlying or emergent themes. Additional coding constructs were created and added to the codebook. At the completion of the deductive and inductive coding processes all thematic nodes in NVivo were checked for the appropriateness of the coding and any alteration required to coding was made.

Observation notes were analysed for key aspects of the performance of governance including the setting, the contribution of participants, and the nature and length of discussion on each agenda item.

Once all data sources had undergone separate initial thematic analysis, a further process was undertaken on the entire data set with a focus on the two research questions. The first area of focus identified processes related to the two key tasks of healthcare quality governance studied, evaluating healthcare quality and overseeing quality priorities. This was a lengthy iterative process that involved multiple reviews of the entire data set. Evidence confirming the existence of processes supporting a key task already identified in extant literature were first sought. These known processes were later supplemented with additional processes, emerging from the review of data, that supported a task objective.

An indicator of governance engagement in healthcare quality was derived from examining taskwork processes related to the two tasks of governance selected for review, evaluating healthcare quality, and overseeing quality priorities. These two healthcare governance tasks were selected from the four identified in Chapter 2 based on their relative importance and the relative ease of corroborating these processes through the research methods used. A list of all key processes related to each task was developed. A point was assigned for evidence of a process related to a task being undertaken. High or low engagement levels were allocated to each case based on the sum of engagement points. Undertaking the count and allocating engagement levels was a simple mechanism used in this study to broadly indicate cases of different activity levels for the purposes of analysis and was not intended to be a process for measuring engagement. Activity counts such as this have been used previously in healthcare governance literature (Bismark et al., 2013).

The second stage of analysis of the entire data set involved a thematic review of case studies to identify influences on engagement. Cases with similar and contrasting levels of engagement were compared to identify patterns of similarities and differences in the presence of constructs. In this second stage the thematic analysis was initially a deductive process guided by consideration of constructs in the conceptual framework.

This was subsequently supplemented by inductive reasoning to identify additional constructs operating to influence governance.

4.5 Research quality and limitations

A vast number of approaches to assessing the quality of qualitative research exist and vary depending upon methodological underpinnings (Mays, Pope, & Popay, 2005). Accordingly, discussing research quality can encompass terms such as 'trustworthiness' (Creswell & Miller, 2000), 'rigor' (Morrow, 2005) and 'convincingness' (Stewart, 2012) or use the language of science more explicitly with notions of validity, reliability and generalisability (Mays et al., 2005; Yin, 2009). Irrespective of which tradition is favoured, the overall objectives of establishing research quality are to determine that the research methods used were reliable and can be reproduced by another researcher (or the same researcher on a different occasion) and that the interpretation of data is a sound representation of reality (Mays & Pope, 1995; Richards, 2009). The ultimate aim of research quality is then to ensure inferences drawn from the data correspond as closely as possible to the phenomenon under investigation (Creswell & Miller, 2000; Patton, 2002). The focus, in this section, is on accepted strategies used to enhance research quality and encompasses the broader literature that spans multiple qualitative research paradigms.

The rigour of data collection and management was aided by the use of a codebook to ensure consistent and reproducible approaches to interview coding (Mays & Pope, 1995; Morrow, 2005). The limitations of a single coder were addressed through a review of coding decisions after the initial coding (Baxter, 2008). Similarly, schedules were used for the document review and observations to ensure consistent recording. Input was sought from two supervisors regarding the suitability of the data collection approaches, coding and thematic inferences which enhanced the rigour.

The limitations of individual methods of inquiry were addressed through using multiple methods to improve understanding and provide greater confidence in the findings (Patton, 2002, p. 92). The use of multiple sources of data and a range of participants from various backgrounds, in this study, provided a broad approach to data collection from which to draw the analysis (Baxter, 2008). The different data sources and multiple perspectives on the act of governance together provided a more complete picture of

governance than any single method (Patton, 2002; Baxter, 2008). The data sources were triangulated through comparing and contrasting accounts to find corroborating evidence to confirm the influence of constructs (Creswell & Miller, 2000).

The extent to which research yields the same result by different researchers or on different occasions by the same researcher (Mays & Pope, 1995) requires careful documentation of research processes. The development of a clear audit trail (Creswell & Miller, 2000) in which data collection and analysis processes have been clearly documented (Patton, 2002) has been undertaken in this chapter.

Another key approach to promoting research quality is researcher reflexivity (Morrow, 2005). Reflexivity refers to the processes of researchers making transparent their assumptions, bias and beliefs (Creswell & Miller, 2000). This is important in developing awareness and possible methods to control bias (Morrow, 2005). Being well-versed in the traditions and conventions of healthcare governance, the lens I applied to interpreting interviews and observations is subject to bias. The challenge was to view the spectacle of governance through the theoretical lens of an effective working relationship rather than the lens of accepted norms of healthcare governance. A conceptual framework focussed the inquiry on key constructs identified in the empirical and theoretical literature. This, along with a comprehensive literature review, assisted in controlling bias I may have brought through increasing exposure to and familiarity with a range of viewpoints and perspectives on governance (Morrow, 2005).

A key limitation of the case study design, often referred to in the literature, is generalisability (Mays et al., 2005; Crowe et al., 2011). Given the small sample size and purposive sampling of the case studies in this thesis the findings are not statistically generalisable in the same way as scientific approaches establish samples which reflect the characteristics of the broader population (Tsang, 2014). The aim however was for analytic generalisation (Yin, 2009), in which the results are generalised to a theory. The comparative case study design provides the opportunity to test and refine theory in the conceptual framework. Determining external validity (Yin, 2009) or transferability (Lincoln & Guba, 1990) requires an assessment of how well that theory applies to a new setting. Given, social phenomena are context specific, the application of that theory to a

new setting can be made if the context of the new setting is sufficiently alike to the setting in which the research was undertaken (Lincoln & Guba, 1990).

4.6 Chapter 4 Summary

This chapter has highlighted that the choice of the comparative case study design was directed by a need to develop a deeper understanding of healthcare governance practices and factors that influence that practice. A comparative case study approach allowed a comprehensive exploration and testing of constructs within the conceptual framework, representing the complex phenomenon of governance, within a natural setting. The use of multiple data collection methods, within the comparative case study, was intended to mitigate the limitations of any single data collection method used. Multiple methods permitted triangulation and convergence of evidence to strengthen findings.

This chapter set out in detail the processes undertaken in initiating, collecting and analysing the data. The cases introduced here and are expanded on in the following three results chapters. The next chapter, Chapter 5, addresses the question of 'how' boards and senior managers govern healthcare quality and develops an indicator of engagement in governance taskwork at each case. Chapter 6 and 7 outline input and mediator constructs, respectively, found to influence governance engagement in healthcare quality to address the question of 'why' there is variation.

Chapter 5 Healthcare Governance Taskwork

5.1 Introduction

This chapter examines the first research question, how do senior managers and board members work together in governing healthcare quality? Literature presented in Chapter 2 indicates a positive association between more engaged boards and healthcare outcomes. However, most research has been undertaken through examining engagement in a limited number of governance processes via survey methods. Through analysing data from the cases this chapter provides a more complete picture of processes of governing healthcare quality than previously described. This comprehensive view of governance work allows cases to be differentiated based on their level of engagement in these processes. Identifying high and low engagement cases provides the basis for comparative analysis of similarities or differences in factors influencing engagement in Chapters 6 and 7.

In this chapter the focus on governance processes represents an exploration of taskwork mediators in the conceptual framework as highlighted in red in Figure 4.

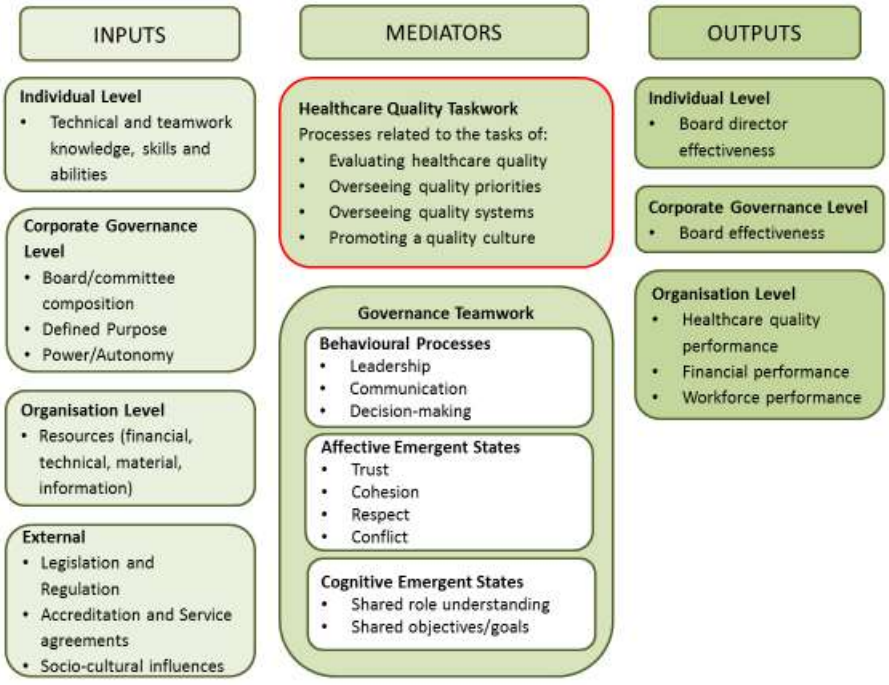

Figure 4: Taskwork in the conceptual framework

Four main tasks of governing healthcare quality, commonly cited in the literature (see Chapter 2, section 2.3.4.), and presented in the conceptual framework are:

- evaluating healthcare quality
- overseeing quality priorities
- promoting a quality culture
- overseeing quality systems.

A comprehensive analysis of processes related to the first two tasks, evaluating healthcare quality and overseeing quality priorities, is undertaken in this chapter. These two tasks were selected based on their relative importance as reflected in the literature and the relative ease of corroborating these processes through observation, interviews and document review.

The detailed interrogation of taskwork, embarked upon in this chapter, is necessary to provide evidence of processes occurring in cases. Processes were identified through their use in selected cases in which the process advances the task objectives, and not by their consistent use in cases, as engagement in these processes varies among cases. The processes identified are condensed in dot points at the end of each section and a summary of all process is presented in Table 19 at the end of the chapter.

Findings presented in this chapter highlight healthcare governance processes, related to two tasks of healthcare governance, which have received little attention in the literature to date. Processes related to the formatting and content of standalone reports are found to be important and demonstrate wide variation between cases. Processes used by cases to highlight performance variation and action taken, foster valuable governance insight. Processes of cascading and making transparent specific quality priorities at the governance level in order that they can be monitored are less obvious in cases but found to be important. Many of these governance processes are initiated or undertaken by management and highlight the work of governance involves both board members and management.

5.2 Evaluating healthcare quality

Key processes related to the task of evaluating the quality of healthcare delivered within a hospital are outlined in this section. Processes related to this task include: defining

quality healthcare; identifying suitable data to inform the evaluation of healthcare quality; presenting data using dashboards and reports; identifying performance variation; and overseeing the effective implementation of action in response to underperformance. Cases demonstrated variable engagement in these processes.

5.2.1 Defining healthcare quality

> *To proceed to measurement without a firm foundation of prior agreement on what quality consists of is to court disaster (Donabedian, 1988, p. 1743)*

As discussed in Chapter 1, quality is an abstract concept that requires definition to highlight how it is measured. An important first step in selecting data to inform an evaluation of healthcare quality is making explicit how quality is defined (Hundert & Topp, 2003; Heenan et al., 2010). Definitions of healthcare quality used by cases fall into two main categories, measurable and procedural. Measurable definitions of healthcare quality describe clinical process and outcome categories that can be measured. Procedural definitions provide categories reflecting organisational systems and strategies through which quality of care is achieved.

C4 and C5 provide measurable definitions of quality with terms including safe, effective and consumer-centred care. C4 also provide a procedural definition, along with three other cases (C3, 6, 8), which address categories of consumer participation, clinical effectiveness, effective workforce, and risk management. Frequent use of the procedural definition in Victorian cases reflects the influence of a Department of Health clinical governance framework current at the time of the case studies. While this document fleetingly mentions measurable quality dimensions (State of Victoria, 2009, p. 9 & 42), it focusses predominantly on procedural domains. NSW cases use a state government compendium as their organisational governance framework and this did not contain a definition of quality care reflecting the absence of any quality definition in the two NSW cases (NSW Ministry of Health, 2012). A previous policy iteration had included a measurable definition, as explained,

> *In the end of 1999- 2000 NSW released the framework for improving the quality in health care and then had the six dimensions of patient*

quality and safety. But interestingly we have sort of got away from looking at those dimensions. (IP7, DoQ, C2N)

Several interviewees from cases with procedural definitions lacked clarity regarding the definition of quality healthcare. The challenge 'to work out what actually quality is' (IP29, BQC chair, C6) is experienced not only by board members but by management.

It's a challenging area to say the least, about getting that governance right around safety and quality. Cos it's, it's sometimes hard to put your finger on it, what it is. (IP35, CEO, C8)

This contrasts with cases with measurable definitions. 'Our definition of quality in this organisation is safe, effective and person centred' (IP23, DoN, C5). The value of a measurable definition of quality is identified by several people, including the following interviewee.

We haven't had the discussion on what is quality to the board. And that's something I'm keen to do … So, the board start thinking what quality to them is. How do they want to measure it? (IP35, CEO, C8)

The use of both types of quality healthcare definitions, as well as the presence of clinical governance definitions in quality or clinical governance frameworks is summarised in Table 7.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Quality healthcare definition exists and consists of:			✓	✓	✓	✓		✓
• Measurable categories				✓	✓			
• Procedural categories			✓	✓		✓		✓
Clinical Governance definition exists	✓		✓	✓		✓		✓
Definitional categories used to identify data				✓				
Definitional categories used to structure reporting	✓							

Table 7: Use of quality and clinical governance definitions

A measurable quality definition assists managers and board members to understand the elements that make up quality healthcare. The relevance of a broad range of indicators used to inform quality performance assessment is then apparent.

Some cases use a process of structuring reporting via conceptual categories to reinforce the multidimensional nature of quality. C4 uses measurable quality categories to identify information for reporting. C1 uses procedural clinical governance categories to structure board reports.

> *I consistently present within the domains of clinical governance. So, I think it's the constancy of the story that we, and thirdly the reports that we provide, our standard reporting aligns with the clinical governance and we consistently in the background actually provide that information so that it continues to give the consistent message. (IP3, DQ, C1)*

Structuring quality reports using conceptual categories consistent with organisational definitions of quality and/or clinical governance supports a shared understanding of key concepts. This promotes the use of a broad range of data to inform multiple dimensions of quality healthcare performance or procedural categories of clinical governance.

Developing a measurable definition of quality is a key process that furthers the task of evaluating healthcare quality through enabling identification and measurement of a range of appropriate data. Key processes in relation to defining and using healthcare quality concepts can be summarised as:

- Board endorses a definition of healthcare quality
- Healthcare quality defined in measurable conceptual terms
- Conceptual categories are used to identify and structure data for reporting.

5.2.2 Reporting quality data

The need for regular, robust and timely board quality reports is a key process identified in the literature (Prybil et al., 2010; Mannion et al., 2015). While all cases satisfy the requirement for regular quality reporting, the format and content vary widely. Research

survey questions often focus on quality data in dashboards and scorecards (Vaughn et al., 2006; Jha & Epstein, 2010; Jiang et al., 2012).In practice, multiple reports are used at the governance level to convey complex healthcare information. Key processes associated with data presentation in the main quality reports at the board and BQC are examined below in relation to dashboard reports and standalone quality reports focussed on specific programs or areas of healthcare quality.

Dashboard Reports

Most cases have reports either referred to as scorecards or dashboards which include a summary of quantitative data in tables or graphs that are reported regularly at the corporate governance level reflecting key areas of operational performance such as quality healthcare, workforce, efficiency and finance. Dashboards and scorecards, employed by cases, were largely similar kinds of mechanisms and therefore are referred to herein as 'dashboard' reports. Seven cases present a dashboard containing quality healthcare data to all board members, of which six were part of a broader report on organisational performance. An examination of indicators used in the dashboards relating to the dimensions of safety (harm), accessibility (waiting times), effectiveness (patient outcomes), appropriateness (processes of care) and acceptability (patient experience) of care was undertaken. Indicators related to efficiency were not examined as these dimensions relied heavily on government performance agreement indicators and reports and showed less variation between cases. Figure 5 demonstrates the number and type of quality indicators within the main board dashboard as determined from the most recent papers available in the document review in each case.

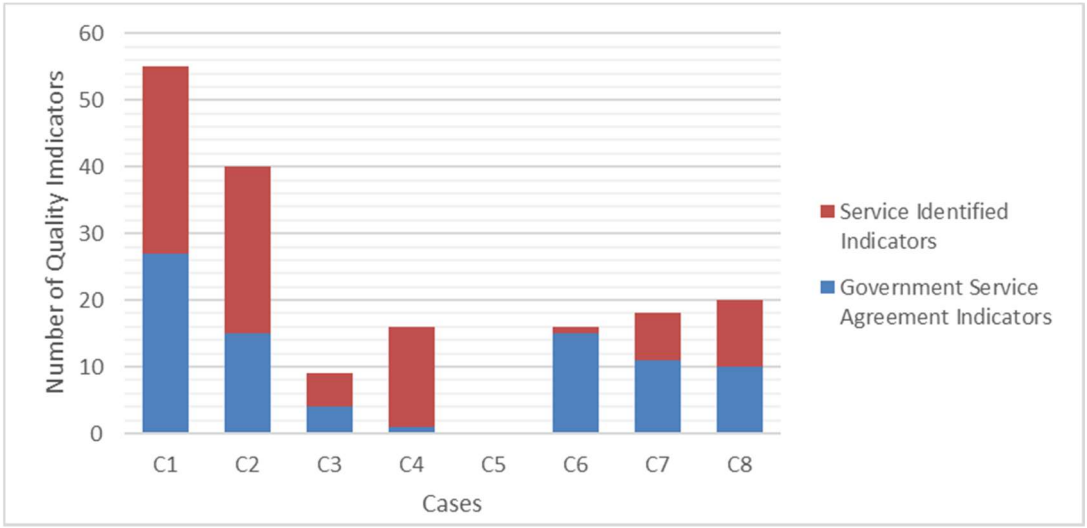

Figure 5: Number and source of quality indicators in main board dashboard

The total number of indicators included in the board dashboard report range from 55 quality indicators at C1 to none at C5 where a dashboard is not present. The presence of a large proportion of measures that reflect government service agreement indicators is evident in most cases. While compliance considerations are an obvious influence on the selection of indicators reported to the board, some interviewees acknowledge the need to balance service agreement indicators by '' add[ing] a few things over time...we think are important (IP6, CEO, C2N).

The number and type of service-developed indicators identified from sources other than performance agreements vary between cases. At C4, the board dashboard report is derived mainly from locally identified indicators addressing maternity outcomes, clinical processes and incidents. Similarly, at C1 indicators represent a broad range of quality and safety indicators, including indicators on key processes such as percentage of records with discharge summaries present and those completed in the required timeframe. At C3 and C8, these service-developed indicators are largely made up of incidents counts or incident rates.

The document examination revealed the main board dashboard is not the only dashboard generally presented at a corporate governance level. Additional dashboards are routinely used in board quality directorate reports or at the BQC. The frequency of the more common indicators, those used in three or more cases, is compared within the main board dashboard and all dashboards at the board and BQC in Table 8.

Data Category	Indicator Description	Indicator frequency in main board dashboards (n=8)	Indicator frequency in all dashboards (n=8)
Safety	Number of serious incidents (ISR1 and 2 or SAC 1 and 2)	3	6
	Medication incidents measures (number or rate)	3	7
	Falls incident measures (number or rate)	4	8
	Pressure injuries measures (number or	5	8

	rate)		
	Patient safety culture	3	3
Effectiveness and Appropriate	*Staphylococcus aureus bacteraemia rate (n=4)*	3*	4*
	Maternity outcomes (including low APGAR, perineal tear, post-partum haemorrhage, caesar rate)	3	4
	Hand Hygiene Compliance	4	6
Acceptable	Patient experience survey (overall experience of care)	4	5
	Timely complaints resolution	4	6
	Met accreditation standards (national or program specific)	3	4
	Met cleaning standards	3	3
Accessible	Access targets	5	6

*smaller sample as only applicable to four cases

Table 8: Frequency of more common indicators in governance dashboards

Table 8 demonstrates there is a higher frequency of reporting on most common indicators when all dashboards are considered compared to when a single board dashboard is reviewed at each case. Reviewing a board dashboard by itself does not give an accurate picture of the data presented at a governance level. When additional dashboards are considered there is less variation evident in indicator reporting in dashboards between cases. The document review, however, did reveal greater variation in other forms of quality reporting at a governance level as outlined in the next section.

Standalone Quality Reports

The main quality items reported to the whole board (in addition to BQC minutes and BQC verbal reports), as determined from standing items on agendas and calendars, are shown in Table 9.

Common Report Types to whole board	**C1**	**C2N**	**C3**	**C4**	**C5**	**C6**	**C7N**	**C8**
Dashboard	✓	✓	✓*	✓*		✓	✓	✓
Standing quality item on the agenda		✓	✓ *	✓*				
Quality Manager or Director report monthly	✓	✓	✓ *				✓	
Board walk-arounds			✓	✓	✓			

Consumer story/case presentation		✓		✓	✓		✓
Patient experience of care report	✓		✓ *			✓	
Culture report	✓						
Serious incident reports		✓			✓		

* via committee at which whole board attended

Table 9: Scheduled quality reporting format to whole board

While C8 has only a dashboard report containing healthcare quality data presented to the whole board, most cases supplement this with one or more other quality reports. All cases have a dedicated finance report at the board, but only some have a quality or directorate report at which key quality issues are outlined. At most cases there is limited whole of board exposure to a range of quality reports, except at C3 where all board members attend the quality committee. This limited reporting on quality at the board level means the BQC is the main forum for comprehensive exposure to quality data and reports. Effective communication from the BQC to the board on quality issues is therefore essential.

Reports that inform the evaluation of healthcare quality and are regularly presented to BQC are outlined in Table 10. This table includes only stand-alone reports that are included as agenda items, rather than elements of quality information in other reports. For example, an incident report refers to a report devoted to reporting of incidents across the organisation, rather than a subset of incident information within a program, facility report or dashboard.

Category	Standalone Report Type	C1	C2 N	C3	C4	C5	C6	C7 N	C8
Acceptable	Consumer stories		✓		✓			✓*	
	Patient experience	✓	✓	✓	✓		✓	✓	✓
	Compliments and complaints	✓		✓	✓		✓	✓	✓
Safe	Incident reports	✓	✓		✓	✓	✓	✓	✓
	Reviews of serious clinical incidents (RCA or clinical reviews)	✓	✓		✓	✓		✓	✓
	Clinical risk profile report	✓	✓			✓	✓		

	Insurance claims				✓				
Appropriate and effective	Medical Credentialing	✓					✓**		
	Clinical audit report		✓			✓	✓		✓
	AHPRA investigation					✓			
	Other external quality indicators***	✓	✓	✓	✓	✓	✓		
Compliance	Accreditation related reports	✓	✓	✓	✓	✓	✓	✓	✓
Annual Operational reports	Clinical risk operational committee annual reports	✓		✓				✓	
	Program/Service area annual reports	✓	✓	✓		✓			
Facility Reports			✓	NA	NA		NA	✓	NA
Committee reports	Single operational quality committee minutes	✓		✓		✓			
	Multiple operational quality related committees		✓		✓		✓	✓	✓
	Community Advisory Committee report or similar	✓			✓				

* in depth case presentation

** separate committee reporting to board exists

*** (e.g. Health Roundtable, ACHS, Dental, Aged Care, Dr Foster)

Table 10: Regular healthcare quality performance reports to BQC.

While all cases have dedicated incident and accreditation reports there is considerable variation in other reports used to inform healthcare quality evaluation. For example, annual reports from programs or operational committees investigating clinical risk are used by a few cases to provide a sharper focus on specific areas of healthcare quality.

Cases also vary in reports received from subordinate committees, with C6 receiving up to seven operational committee minutes for review. A board member comments this approach makes it difficult to identify key issues as important information is 'buried in these minutes' (IP29, Board member, C6). This is in contrast to C1, which receives one set of minutes from an operational quality committee and relies on annual reports for assurance on progress with other operational committees addressing specific clinical risks.

Individual report types vary in comprehensiveness as outlined below using two of the more common report types, incidents and patient experience, as examples.

Incident reporting

Reporting on incidents occurs in three main ways in cases: dashboard indicators of number, rate or type of incidents; summary stand-alone reports on all incidents; and, detailed stand-alone reports on serious incidents. While all cases have incident indicators in their dashboard reporting they vary in their use of stand-alone reports. BQC summary stand-alone reports on all incidents vary from the absence of a stand-alone report at C3, to C1 providing a comprehensive periodic incident report examining rates, types, location, severity rating, timeliness with incident management processes and an annual thematic report giving longer term trends analysis. Dedicated BQC reports on serious incidents are provided in 6 cases and vary from detailed verbal presentations of individual clinical case management (C8), to a comprehensive annual thematic analysis of contributing factors and review of implementation of recommendations (C1 and C2N). C3 and C6 have dashboard indicators on total number of serious incidents, but no dedicated report.

The limitations of incident data are widely acknowledged in the literature and this is noted, uniquely, in the board briefing document at C1 which states, 'whilst the limitations of incident reporting are recognised and acknowledged, it is important to note that incident reporting and analysis provides valuable information to inform continuous improvement of patient quality and safety' (C1, incident report, BQC papers, August 2016). Incidents are often poorly defined, uncommon, and reporting on numbers and rates are usually influenced by reporting culture at an organisation and may not reflect the actual number of incidents occurring for a defined population (Vincent, Burnett, & Carthey, 2013; Duckett et al., 2017). More comprehensive information on incident severity, location, type and contributory factors, as seen at C1, is therefore useful in informing an understanding of why incidents occur.

Variation in stand-alone reports on incidents highlights differing understandings of the purpose of reporting. Where detailed individual patient actions are the major component of serious incident reporting, as at C8, the focus is on operational management. Where the number or rate of incidents is provided, as at C3 and C6, the

focus appears to be on event management. Comprehensive reporting and annual thematic reviews, as at C1 and C2N, indicate a quality improvement approach with the clear intention of seeking to understand factors contributing to serious incidents. This latter approach aids problem definition and supports selection of appropriate actions, as explained by this quality manager who is conscious of the absence of this quality improvement approach at their organisation.

> *So, I just present KPI's. We do aggregate kind of data analysis here. But we don't do it in a formal way and say all right at the end of the calendar year let's analyse all the incident data. Let's really identify what the issues are and then let's work out priorities, from a system level. (IP22, MQ, C5)*

Reporting on patient experience

Data on patient experience is obtained in four main forms at a governance level: consumer stories or case presentations; a state department-generated patient experience survey report; organisation-generated patient experience report; and, a compliments and complaints feedback report.

C1, 2N and 4 demonstrate a comprehensive approach to reporting patient experience through multiple report types. For example, C1 has three of the four reports, including a periodic report on multiple sources of patient generated feedback and experience which is themed over 12 months according to internally generated principles for patient experience. These cases contrast with C5, which presents patient stories at the board and select survey indicators via a committee dashboard but no other stand-alone report.

State Department of Health-run patient experience surveys provide an opportunity to demonstrate clearly this variation in reporting approach between cases. All cases within a state receive the same state report in an identical format varying only in the identification of organisational details. Cases differ in how these patient experience survey documents are reported. At C7, information from the patient experience report is not presented at the governance level. At C5 and 8, the government report is summarised via one or more quantitative government performance agreement

indicators in a BQC dashboard. At C8, this is a single indicator from the state patient experience survey, subject to a departmental pricing for quality incentive. This contrasts with the remaining five cases that provide the entire report and in four cases (C1, 2N, 4, 6) this is accompanied by a briefing paper summarising the issues and actions. Variation in understanding what constitutes important governance-level information in relation to patient experience is evident. Comprehensive reporting of state patient experience survey results with briefing papers highlights cases using reports to inform understanding of current areas of strength and areas for improvement. In contrast, the cases that report a few performance agreement indicators have a compliance focus.

A summary of the patient experience reports provided at each case is provided in Table 11.

Report type	C1	C2N	C3	C4	C5	C6	C7N	C8
Consumer story/case presentation		✓		✓	✓		✓	
State patient experience survey	✓	✓	✓	✓		✓		
Organisation patient experience survey	✓	✓						
Compliments and complaints feedback	✓		✓	✓		✓	✓	✓

Table 11: Patient experience stand-alone reports at Board and BQC

While the healthcare performance literature has focussed on the content and format of the main board dashboard report the review of quality reporting at the corporate governance level, provided in this section, reveals less variability in data within dashboard reports and much greater variability in stand-alone quality reports between cases. Cases vary in their presentation of a range of internally generated reports such as, patient feedback reports, clinical risk profiles, clinical audit program reports, program area reports and in the use of 'soft intelligence' (Dixon-Woods et al., 2013) in the form of consumer stories, case presentations and walkarounds. Cases also vary in their use of data from external reports, as demonstrated in examining use of the state generated patient experience report.

A range of approaches exist to governance reporting of quality data, even when the same data is available to cases (as in the state patient experience report). Varied approaches to stand-alone quality reporting indicates differences in understanding the purpose of governance reporting.

Key processes in relation to reporting quality data at the board and BQC include the following:

- Regular reporting of quality data
- Presentation of dashboard/s with indicators representing a range of quality dimensions and risks
- Dashboard reporting at board supplemented with more detailed quality report or directorate report
- Presentation of stand-alone quality reports supporting a quality improvement approach and providing overview of:
    - quality dimensions and key systems (e.g. incidents, complaints)
    - key risks (e.g. falls committee annual report)
    - program reports.

5.2.3 Identifying variation

Healthcare quality data needs to be reported in a way that enables boards to easily identify and understand unacceptable variation. Trending and benchmarking are formatting requirements cited in the literature, that promote this (Jiang et al., 2009; Jha, 2010; Bismark & Studdert, 2014). Benchmarking and target setting have, on occasions, been conflated in the literature with ambiguous statements made such as 'using a dashboard with national benchmarks' (Jiang et al., 2009) or benchmarking against established standards (see for example Prybil et al., 2008; Bismark et al., 2014). Benchmarking is the practice of comparing an organisation's performance with that of others in the same or different sectors to drive improvements to those of the best performers (Kyrö, 2003). Targets reflect expectations set within the organisation or externally, and may not necessarily be derived from an analysis of performance from a benchmarking exercise. Mechanisms used to identify performance variation in both dashboard and stand-alone reporting are examined in the cases.

Dashboards

Two main components of dashboard reporting are noted in the document review and included a summary indicator table and/or detailed graphs of indicators usually accompanied by commentary. Not all cases have both these components, and C5 presents neither.

At C1, the dashboard consists of a summary indicator table indicating the target, 5-month performance, trend and traffic light. This is supplemented with detailed indicator graphs and tables with 2-year trend, target or benchmark and data analysis commentary for each dashboard indicator. This contrasts with C7, which provides only a summary indicator table with one month's results with target and trend. Six out of seven cases provide detailed indicator graphs and commentary to more fully explain indicators outlined in the summary indicator table. These graphs aid interpretation of indicators through visual representation of trends and the commentary often highlighting issues of concern or action.

A range of mechanisms is used in dashboards to aid identification of variation. Integral to identifying variation is the setting of targets or thresholds derived from internal trend data, benchmarking or service agreement targets. C1 have a framework accompanying the board dashboard that clearly indicates the rationale for indicator target setting and identifies both internal and externally derived targets. C3 uses targets derived from mean sector rates for comparing performance in incident data. C2N identifies targets derived from a departmental service agreement. The rationale for target setting is not transparent in other cases.

The challenge of setting appropriate targets is a key interview theme. For example, in incident reporting there are two main perspectives. The first perspective argues targets for serious incidents should be zero, as setting a target other than zero feels morally unacceptable. 'We don't accept anything less [than a zero target], it was a philosophical thing' (IP25, Board member, C5). However, many interviewees acknowledge the gap between reality and the aspiration of zero harm.

> *If you're the one person in the community that get hurt it's not acceptable. So, we have zero tolerance for preventable harm but achieving tolerance is, it is really challenging. (IP22, MQ, CS5)*

> *We'll look at items that are stubborn reds or stubborn ambers and why aren't they moving. A classic one is falls and there's so much going on with falls but it's not translating into the data because we continue to have falls, every health service does. But our target is to get this to zero, but it's just not realistic. But we don't then accept that. We don't accept the fact that people say that better to have a more realistic target. Well, why should you have a target of patient harm, its anathema to providing a safe environment. (IP5, Board member, C1)*

The alternate perspective argues that health is a risky business and risk can never be eliminated in some areas due to the nature of patients with complex medical problems. Instead what should be aimed for is incremental reduction in harm. This interviewee explains the use of incremental targets in improving healthcare quality.

> *When [CEO] said there is going to be a hundred percent compliance with the hand hygiene it was just not achievable. You know nobody questioned it … of course it's 100 percent, but that's an absolute stretch target. There's a difference between where we are now and next year we want to be at 70 percent next year. We want to be at 75 and next year we want to be at 80. You know that incremental [improvement], to me, is incredibly important. But you set it at 100 and we never meet it and everyone goes 'we're failing'. Well no, we are getting better. (IP22, MQ, C5)*

At C5, a program of reporting on preventable harm had evolved to distinguish between harm resulting from uncontrollable patient characteristics and those incidents where 'harm was absolutely preventable' (IP23, DoN, C5). This approach is echoed at a couple of other services.

> *And using falls again as an example [quality manager has] always explained fairly clearly that yes, there's a certain amount of falls that aren't preventable. So, we can't stop, you know, zero's not really a*

> *target unfortunately. So, so it's the preventable falls where we really try and focus on and work out. (IP20, BQC chair, C4)*

The use of external benchmarks as targets, while helpful in indicating the relative performance of the organisation, is felt by one interviewee to not necessarily indicate acceptable performance or an appropriate target.

> *Our bullying level was still better than everybody else, but they're still too high. 18 people, or was it 18 percent, reckon they saw bullying. Whether they did or didn't, they've seen behaviours that they don't like. That's a lot of people, so there must be a mess out there [at other hospitals]. (IP11, CEO, C3)*

Setting targets for healthcare quality is a complex governance activity. At some cases in-depth philosophical and practical discussions are undertaken at a governance level to arrive at a target. In other cases, the basis for target-setting is less apparent. The need for aspirational quality objectives of zero harm is widely recognised, however setting short-term goals aimed at zero harm are perceived by many interviewees to be unrealistic. This perspective is echoed in normative literature.

> *While "Zero Harm" is a bold and worthy aspiration, the scientifically correct goal is "continual reduction". All in the NHS should understand that safety is a continually emerging property, and that the battle for safety is never "won"; rather, it is always in progress. (National Advisory Group on the Safety of Patients in England, 2013, p. 14)*

Target setting is a key process that facilitates performance evaluation and the rationale behind the target set needs to be explicit and understood by both managers and board members.

Traffic light colour coding of results is another mechanism used to signal relative performance in relation to a target. This is seen in all cases that use a summary indicator table to present data in their dashboard (see Table 12). Some dashboards also have short-range trend data and/or trend arrows to assist in identifying changes in performance since previous reporting period/s.

Traffic light coding, short-term trend data and trend arrows do not assist in identifying the nature of variation occurring. When discrete time point data is presented it is more than likely that figures in the previous reporting period will be higher or lower (Mountford & Wakefield, 2017). Changes may be due either to common cause variation, non-statistically significant variation that affect all results in a stable process or significant cause variation, due to unusual or unanticipated but potentially identifiable forces (Mohammed, Worthington, & Woodall, 2008; Neuhauser, Provost, & Bergman, 2011; Anhøj & Hellesøe, 2017). Changes in discrete time point results can trigger red or orange codes in response to non-significant or common cause variation or the normal 'noise' (Schmaltz, Williams, Chassin, Loeb, & Wachter, 2011, p. 4; Schmidtke et al., 2017, p. 61) within a process. Red and orange flags triggered in relation to unrealistic targets can draw the board into unnecessary discussion of normal or common cause variation. This is a concern for many of the interviewees.

> *There's so much reactive stuff that comes from the department at quarterly meetings, you know, your performance is deteriorating in, you know, factor X. But when you look at it and go through the data, it's not statistically significant it's just common cause variation and it actually, you know, when you've got minimal resource to focus. But what it does is send a red flag to the seniors and the board go 'oh my god we're not doing well in this' but in fact we're actually, we're OK. (IP22, MQ, C5)*

Frequent generation of red and orange flags in relation to the same indicators is seen by some to lead to 'habituation'. One board member describes the problem 'if you ask a meeting every time about every red [trigger] you'd be asking the same question every time. You'd be bogging the meeting down' (IP21, Board chair, C4). Repeatedly managers lamented their board's focus on red flags associated with patient falls at the risk of ignoring other important issues.

The need to distinguish between common cause and significant cause variation is acknowledged by several interviewees, 'you need a control chart' (IP17, DMS, C4). Process control charts or funnel plots that provide time series data with statistical upper and lower limits of 2 or 3 standard deviations from the norm allow a quick visual method of distinguishing between common cause or significant cause variation. Three

cases (C2N, 4, 5) use process control charts for select internally generated data as part of the detailed graphical section of the dashboard report. This more sophisticated form of identifying performance variation, reflects a clear understanding of the need to ignore the normal noise associated with processes and to focus attention and resources on performance variations that are significant.

Disaggregated or 'more granular data' (IP10, Board member, C2N) is also important in identifying variation. As noted by one interviewee, the pressure to present data at an aggregated level or the 'big picture stuff' can result in missing 'a micro story here that no one had picked up' (IP6, IP6, CEO, C2N). The interviewee goes on to explain,

> *The national safety quality commission produced a report about safety. And they had funnel plots about staph aureus bloodstream infections. Somehow [facility] was an outlier. Now internally for us, we, at the time … were reporting our staph aureus infection rate at the [LHN level]. And we were looking at it, hunky dory. We're thinking, there's nothing wrong and all of a sudden whack this has come out of nowhere. And what we realized was, what we didn't do [was] the sublevels down. So, some of our safety quality reports you see we now have the lower [facility level reports]. (IP6, CEO, C2N)*

Detailed indicator graphs that give room for commentary on data interpretation are found to be particularly useful in explaining data variations. As one interviewee explains 'the commentary against the stats for me has been phenomenal because I can look at it and go yes that's reasonable' (IP14, Board member C3). The commentary is also seen as a time saving device in meetings.

> *We've added little comments beside the graph so that we can actually give them a bit of commentary because we've only got an hour. So hopefully they've read that and most of them have. (IP13, DQ, C3)*

Many board members welcome knowing 'based on someone's analysis of it, what are the areas of concerns and then what are we doing about it. (IP9, Board member, C2N).

Mechanisms used to identify performance variation in the main dashboard reported to the whole board at each case is summarised in Table 12.

Feature	C1	C2N	C3	C4	C5	C6	C7N	C8
Presence of dashboard report consisting of:	✓	✓	✓	✓		✓	✓	✓
a) Summary indicator table	✓	✓		✓		✓	✓	
• Result provided	✓	✓		✓			✓	
• Target (where applicable)	✓	✓		✓			✓	
• Period trended (months)	5	1		Up to 12		1	1	
• Trend arrows		✓					✓	
• Colour coding performance	✓	✓		✓		✓	✓	
b) Detailed indicator graphs (and/or tables)	✓	✓	✓	✓		✓		✓
• Period trended (months)	24	24	12	variable				13
• Target provided where available	✓	✓	✓	✓		✓		✓
• External benchmark data provided								
• Disaggregated data provided		✓						
• Commentary on data	✓	✓	✓	✓		✓		✓

Table 12: Format of whole board dashboard reporting

Transparent, short term incremental target setting, long term trending, process control charts, disaggregated data and the provision of detailed analysis and commentary on data are valuable processes in identifying performance variation in dashboard reports.

Stand-alone Reports

Variable use of mechanisms to identify variation in healthcare quality in dashboards, discussed in the previous section, is also seen in stand-alone reporting. Additional mechanisms such as briefing papers accompanying stand-alone reports are particularly

helpful in highlighting the implications and significance of complex data presented in reports. The absence of this sort of mechanism in a case results in a CEO noting the difficulty board members sometimes experience in understanding the implications of reports presented.

> 'What is this report? What does it mean as far as our strategy is concerned with achieving our vision? There's none of that questioning. No, it's just accepting the report. A bit of discussion, do we need to be concerned about it, perhaps, and then moving on? (IP35, CEO, C8)

Approaches to identifying performance variation in stand-alone reports is highlighted in Table 13 using incident reports, a report produced by all cases.

Format of incident reports	C1	C2N	C3	C4	C5	C6	C7N	C8
Summary briefing document with background, analysis of data, recommendation/summary of action	✓				✓			
Provision of graphs	✓		✓	✓	✓		✓	✓
Provision of indicator tables	✓	✓			✓		✓	✓
Provision of trended data from 6-36 months	✓	✓	✓	✓	✓	✓		✓
Evidence of control limits on some graphs		✓		✓	✓			
Provision of targets				✓		✓		✓
Provision of benchmarked data								
Disaggregated data by facilities or programs	✓	✓	-	✓	-	-	✓	✓
Narrative analysis of data	✓	✓	✓	✓	✓			
Identification of actions		✓	✓	✓				

Table 13: Format of incident reports

The variable use of mechanisms to identify variation in incident reporting in Table 13 is replicated across most quality stand-alone reports viewed at cases.

Several cases are notable for producing stand-alone reports aimed at revealing underperformance in specific areas. These cases use sophisticated mechanisms to

identify problems with care that are not revealed through standard data collections and investigations. All involve the assessment of evidence-based standards of care. At C7N, a project to develop and assess nursing standards of care across facilities was recognising and sharing learning from under-performance and strong performance. At C4, multiple clinical pathways are defined and adherence with the pathways are periodically assessed. C4 and C6 both use an internal audit methodology, teaming an internal auditor with a clinical expert, to examine specific areas of clinical practice. These mechanisms represent significant internal initiatives by cases to define and assess performance against recognised standards of quality care.

The need to balance a focus on under-performance with recognising and sharing learning from strong performance is expressed by several interviewees as 'what are these guys doing really well and how do we learn from that and replicate it' (IP22, MQ, C5). Another interviewee explains,

> *If what we measure is what we value there is a role the committee could play in actually, like the beacon on the hill. As far as showing an interest in the good works that are happening within the LHD and there's plenty of them. Like most organisation we'll spend 95 or 99 % on 5 percent on the things that aren't going right because we are there to manage risk. Fair enough. I think within that we need to look at what we are doing right though. (IP8, Manager, C2N)*

Understanding how things usually go right is helpful in understanding poor outcomes when they occur (Hollnagel, Wears, & Braithwaite, 2015). Strong outcomes reflect clinicians' ability to adapt to constantly varying conditions in complex healthcare settings. Mechanisms of recognising strong performance are rarely apparent in the document review. C5 and C7N report to the board on annual quality and safety awards but systematic approaches to reporting on learning from strong outcomes are less obvious.

Identifying variation in healthcare quality is a complex governance activity that is undertaken in a range of ways in cases. Survey questions in empirical literature have a limited focus on trending and benchmarking. Based on the evidence provided in this section identifying variation can be restated to include the following processes:

- Dashboards are developed with both summary indicator tables and detailed indicator graphs/tables with data commentary summarising key issues
- Internally generated and external stand-alone reports are accompanied by briefing papers which identify relevant system-wide issues and action implemented
- Disaggregated data is provided to identify program-specific issues
- Appropriate agreed explicit targets are set based on short-term incremental targets
- Trended data with prompts to identifying variation through the use of realistic incremental targets or acceptable limits e.g. process control charts
- Internal standards developed by which to assess quality of clinical areas, via mechanisms such as clinical pathway or service audits and internal audit
- Identification and analysis of strong performance.

5.2.4 Action oversight

Documenting action undertaken or planned is an integral part of informing the board of management's response to quality healthcare issues identified, but is inconsistently documented in cases. Some board interviewees are conscious of the need for this process, 'we don't need the commentary to say there had been an increase in falls we get that. What we need is what has been done about it' (IP5, Board member, C1). Dashboards at C1, 2 and 4 usually identify action if indicators show under-performance. These cases have a focus on system-level issues and therefore system-level actions, as opposed to patient-level actions described at some cases. At C8, there is a strong focus on individual patient management actions as explained by the quality manager,

> *This person fells seven time and we did all this and now they are not falling and that's great, but there wasn't a lot of … now we're doing all this to stop someone else falling seven times. (IP36, MQ, C8)*

C4 and C2N use a report format that separates the analysis of data and identification of action against each dashboard indicator. The prompt for data analysis is useful in supporting the identification of factors contributing to variable performance. Accurate identification of contributing factors facilitates the selection of appropriate actions. For example, if, as at C2N, when presenting data on an increase in patient safety incidents,

the data analysis indicated incidents are related to non-preventable factors, such as patient comorbidities, then the rationale for no further action is evident.

The absence of action identification is a problem at other cases and is remarked on by several interviewees. As one interviewee states,

> *Every time you get a report there's 'communication', that's one of the biggest areas for complaint. What do we do about it? Well we just listen to them say 'yes, communication is one of the highest reason for complaints' but we don't do anything about it. (IP33, DoN, C7N)*

Monitoring effective action implementation is equally as important as identifying actions. Improving healthcare is seen to take 'some time to actually get … clear outcomes' (IP25, Board member, C5). The board's role in pursuing issues and ensuring 'that it's monitored and acted on. And then we continually go back until we're satisfied' (IP25, Board member, C5), while seemingly self-evident, is not always straightforward. Follow up is occasionally ineffective as 'sometimes things like drop off or get delayed or other priorities come up' (IP25, Board member, C5).

Some managers appreciate the skill the board bring to monitoring implementation of action.

> *That to me is a really fine balance that comes with a level of maturity around how you operate as a director. Without getting too far into the detail. But keeping everyone, holding everyone [to account] and keeping the focus at the right spot. (IP1, CEO, C1)*

Action lists or business arising are mechanisms used by all cases to follow up outstanding actions arising in meetings. However, these mechanisms are used mainly for governance-related actions, such as requesting a report, rather than logging management actions in relation to system-wide issues identified in reports. The nature of retrospective reporting of quality data at a corporate governance level means that management actions are normally already decided or implemented before reporting occurred. Assurance that actions result in improvement is therefore a key concern felt by board members.

> *That's probably my biggest observation or concern, is that as an organisation I think we are really good at getting all our systems and having that sort of systemic approach having our documentation, our policies and procedures, having that all squeaky clean and perfect. … But does that mean that what's actually happening out there and the things that are coming out of all that data are really being implemented in a meaningful way? (IP21, Board member, C4)*

Persistence is required in following up on implementation, as explained by one board member.

> *A particular thing of mine is the follow up of things that are presented to us, so that we don't just discuss something and wash our hands of it. …. And some of us are particular about ensuring that things don't get dropped off the end. (IP34, BQC chair, C7N)*

At the BQC meeting observed at C8, the persistent questioning of a board member revealed that an action from a previous meeting, requiring recommendations arising from reviews of serious incidents be distributed and discussed by relevant staff, had not been effectively implemented. The CEO explains,

> *The question had been raised 'So what happens to the information afterwards?' and [DMS] saying well he sent it down to the clinic and then the doctors admitting that nothing happened when it got there. (IP35, CEO, C8)*

C1, 2N, 6 have developed review mechanisms to ensure that major recommendations arising from reviews of serious incidents and/or audits are effectively implemented. C1 also has a process for indicators that flag red over three reporting periods to be incorporated into a planning mechanism that is then reported periodically to the board. C6 had a log of progress with implementation of major recommendations for improvement from various sources that is reported regularly at the board. These mechanisms supported effective oversight of action implementation.

The key processes in overseeing action can be stated as:

- Data analysis to identify contributing factors to support appropriate system-level actions to be identified
- Identification of action undertaken or planned/required
- Mechanism for follow up effectiveness of action implementation.

5.2.5 Board-endorsed quality data

Reviewing and endorsing quality data used to inform healthcare quality evaluation is a key board process identified in the literature (Joshi & Hines, 2006; Kroch et al., 2006; Levey et al., 2007; Prybil et al., 2010).Formal and opportunistic processes of reviewing data provide board members with valuable avenues to refine management reports to meet governance needs. A document identifying data selected for reporting on healthcare quality is useful in enabling both a formal review of data and board endorsement. Calendars and/or reporting frameworks are used variably by cases to identify the content, format, frequency and responsibilities for data presentation as shown in Table 14.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Board calendar exists	✓		*	✓	✓	✓	✓	✓
Board calendar identifies quality reports	✓		*		✓	✓	✓	
BQC data reporting calendar exists	✓	✓	✓		✓		✓	
Dashboard indicator reporting framework	✓							

* whole board attends quality committee

Table 14: Reporting frameworks at board and committee

Table 14 shows that calendars documenting board and committee activities are apparent in over half the cases. Of six cases with a board reporting calendar, four have identified the type of quality reports to be presented, although these vary in the completeness of capturing data and reports presented.

C1 is the only case that also provides a detailed framework for board dashboard indicators that document indicator measurement specifications, sources and target.

This document is useful when undertaking management and board annual review of data reporting as explained,

> *So, with the scorecard management, the clinical executive will review it but ultimately the board will test the indicators as well. So, we do the review of the scorecard indicators informed by management, but it is signed off by the board. (IP5, Board member, C1)*

Some other cases undertake more limited dashboard reviews focussed mainly on reviewing data evident within the dashboard, as explained,

> *The dashboards that are the formal documents that go to the board meeting were agreed to by board members and CE and they worked out what it is they wanted. The board chair in particular and [board member] who is one of the board members was very proactive in meeting and working through with [CEO]. So, spent a lot of out of session time going through that. (IP32, DQ, C7N)*

Broader reviews of standalone governance reports are facilitated through transparent reporting frameworks, such as a detailed BQC reporting calendars. These assist in undertaking a formal review of BQC reports.

> *The documentation that comes to the quality committee. We've had, we've had quite a strong say in what it looks like... we do review this and just recently we've talked about other things coming or not coming. (IP4, BQC chair, C1)*

At C2N, a BQC evaluation survey addressing data selection, without specific reference to or examination of a reporting framework, proves less effective and results in little board input to the manager collating the survey.

> *I think there is a question in this survey ask[ing] about the information or the papers that go to that committee, are they relevant and that sort of thing... I've never had any suggestions. (IP7, DoQ, C2N)*

Some cases that lack formal board input into reporting frameworks rely on a management review followed by informal board feedback. One interviewee describes

this as, 'we've tweaked this this time? Let us know what you [board] think' (IP11, CEO, C3). All health services note that incremental changes are made to reporting through discussions that occur at meetings. These 'iterative discussion[s] with the board' (IP12, DMS, C3) are valuable in refining reporting. As one interviewee explains, 'over time we have shaped the reports, the structure and format of those reports' (IP9, Board member, C2N). This continuous process of reflection and modification of reporting is seen as valuable 'because we're constantly looking for, is this the right way to do it now. For the board that we've got and for the situation that we're in' (IP12, DMS, C3). The need for reporting to reflect changing circumstances is explained further.

> *It is an ongoing discussion and I think it's about being alert too and ready for any of those discussions and we have agenda items, what's new. What are the issues that are coming up out of the management for the quality committee? You know what's been flagged, so we're asking the question of management in their committees. What do they think should be coming to the quality committee? What are the things that are new and risks and challenges for us either internally or externally. (IP4, BQC chair)*

Variable use of these processes of reviewing and endorsing board reporting is evident between cases. C1 uses a range of mechanisms to support the review process. This is in contrast to C8, where there is little transparency around the reporting schedule and a lack of review of reporting is evident. The CEO comments,

> *We're… just presenting what has historically been presented for the last couple of years. We haven't had a discussion on are there other things the board wants to be seeing and I don't think we've really sat down as an executive and discussed what else should we be providing. (IP35, CEO, C8)*

Formal and informal mechanisms for board engagement in data selection, endorsement and review are both important in ensuring effective evaluation of healthcare quality. However, formal mechanisms are less apparent in most cases. Board review and endorsement of quality measures can be restated as the following key processes:

- a board and committee data reporting framework is developed which identifies a range of quality indicators and reports
- Periodic management review of data reporting framework with recommendation for changes that are reviewed and endorsed by the board
- Opportunities are created for ongoing iterative discussion regarding changes to reporting in meetings.

5.3 Oversight of quality priorities

Key processes related to the task of overseeing quality priorities at a corporate governance level are outlined in this section. Processes related to overseeing quality priorities include: identifying quality priorities; cascading priorities into subordinate plans and monitoring progress with implementation. While there is some variation in the adoption of these processes between cases, this is a task that is generally undertaken with less rigour in cases.

Of interest in this study are two main types of quality priorities, those identified through strategic planning processes and those identified in response to issues arising or changing external requirements. Planned quality priorities needing substantive long-term resource allocation and/or organisation-wide focus are usually considered in strategic planning. While arguably anything in a hospitals' strategic plan contributes to an overall organisational mission of improving patient outcomes, of interest in this study are strategies related to improving existing healthcare quality. These strategies, in contrast with strategies improving patient outcomes through new forms of service provision, reflect the board driving healthcare quality beyond compliance requirements. One interviewee sums this approach up.

> *We've got good quality. But if we want to move from good to being really high quality. There's a big difference … to take it to another level and really saying look we're doing, we're performing pretty well but we can do better. But we're not, we're saying we're performing pretty well and that's OK. (IP22, MQ, C5)*

Emergent quality priorities, developed in response to newly identified risks or opportunities to engage in external driven quality improvement initiatives, are also

evident in cases. These emergent quality priorities are also important in contributing to improving the existing quality of healthcare.

5.3.1 Quality priority identification

The process of identifying both planned strategic and emergent quality priorities are considered in this section. The need for strategic quality planning is raised frequently by quality staff, occasionally by CEOs, but less frequently by board members with a couple of exceptions.

> *I feel that we're missing out on is that more the, the positive strategic future direction rather than the, you know, just the compliance and reporting up and doing the things we have to. (IP21, Board chair, C4)*

The existence of strategic quality improvement priorities is examined through documentation review and interviews and is outlined in Table 15. A distinction is made in the table between the highest order descriptor of strategy 'pillar' which is a broad strategic heading and subordinate 'priorities' or more specific objectives to address each pillar.

Strategic Plan Feature	C1	C2N	C3	C4	C5	C6	C7N	C8
Pillar/s addressing healthcare quality	✓	✓	✓		✓	✓	✓	✓
Priorities for improving healthcare quality	✓	✓	✓	✓	✓		✓	✓
Priorities for attaining accreditation	✓		✓					✓

Table 15: Strategic planning quality pillars and priorities

As shown in Table 15, C4 is the only case without a quality healthcare pillar and an interviewee reports that a consultant engaged to undertake strategic planning said that 'things like your finance and quality are all givens, they're not part of the strategic plan' (IP17, DMS, C4). However, this omission is felt in the governance focus.

> *There needed to be a direct statement of strategic intent that we provide safe quality care. And it's not there… I mean you can't have it*

> *on the board agenda if it's not part of your strategic planning. (IP18, MQ, C4)*

A later revision of the strategic plan at C4 addressed the gap with a healthcare improvement priority added under an existing pillar. Having a strategic pillar addressing healthcare quality is seen as an important process.

Table 15 shows that most cases have specific priorities, under a broad pillar, related to improving the existing quality of care. C6, is an exception, with multiple priorities relating to expanding clinical services or service models, but none specifically aimed at improving the current state of healthcare quality. Most of the priorities for improving healthcare quality are couched broadly in terms similar to 'meeting or exceeding standards of care' (C1, C5) or 'improving the quality of patient care' (C2N, C3, C5, C7N, C8). These broad strategies are seen as being 'a bit loose, I think that's been hard for people to operationalise (IP16, CEO, C4). The need for more specific priorities or 'clearer strategy, because it's very hard for us to do our good work of governance without knowing what the priorities are' (IP9, Board member, C2N) is felt at a few cases. A CEO explains,

> *While the directions are probably OK the detail underneath them about actually being much more explicit in what we're actually looking to achieve [is missing]. (IP1, CEO, C1).*

The lack of specific and measurable planned strategic priorities in most cases creates a vacuum where staff and board members find it hard to articulate and operationalise strategic initiatives. The solution is seen in developing 'a clearly defined quality goal and it might only be one or two for the organisation' with appropriate resourcing and 'driven by all the data' (IP22, MQ, C5). The interviewee goes on to explain,

> *If I said … we are going to eliminate sepsis, hospital acquired sepsis in the acute hospital by June 2017, people know what it means. Yet, where to me 'providing the right care' … it's a catch all phrase. But there's no specific thing that if you walked around and spoke to everybody and said what are the safety and quality goals for [organisation name] this year. They wouldn't know. (IP22, MQ, C5)*

This lack of strategic drive meant that quality priorities undertaken are driven by either external opportunities or requirements or management initiatives or response to issues. Identifying clear, specific strategic priorities for quality improvement is an important governance process.

Three cases (C1, 3, 8) have meeting accreditation requirements as a strategic priority. At C8, this relates to an historic fear of failing accreditation.

> *I've put it to [the board] that accreditation shouldn't be on the risk register because we passed organisation wide survey and we've passed periodic review. It should be business as usual. So why waste time focussing on accreditation. "Oh no, if we don't pass accreditation we won't be funded. It's a huge risk to us". No, it's not. (IP35, CEO, C8)*

This focus on accreditation in strategic priorities, in some cases, reflects a focus on compliance requirements as strategic drivers. Rather than seeing accreditation as an ongoing operational requirement requiring board assurance it is seen as a strategy to improve healthcare quality.

At most cases there is evidence of substantive quality improvement initiatives being initiated and undertaken at an operational level. However, the alignment between these operational quality priorities and organisational strategy is often missing, as explained,

> *If we paired it back we've got a big falls program going on at the moment, we've had the pressure wound stuff. So, if we look three years ago, yeah, I think we're doing it and this is what we're not good at, setting the big picture and then measuring what we're doing and getting to that end game. But we do all the activities in the middle, but we don't tie it together. (IP16, CEO, C4)*

This malalignment is seen by a few management interviewees to result in a failure to ensure that quality priorities are appropriately resourced through the 'operational budget [being] tied back to the priorities' (IP16, CEO, C4). Emergent priorities are seen as important and yet not transparent at the governance level.

The presence of broad strategic quality improvement priorities is evident in the study. However, their effectiveness in generating specific quality strategies is less evident. This combined with a lack of transparency around emergent quality priorities means that there is poor engagement in process to identify quality priorities at a governance level at most cases.

Processes that are relevant to identifying quality improvement priorities can be stated as:

- Create a key strategic planning pillar that addresses improving the current status of healthcare quality
- Identify, prioritise and resource specific priorities, both planned and emergent, to improve healthcare quality.

5.3.2 Cascading strategy

Cascading strategic quality priorities, the process of 'strategy deployment, pushing it down, pulling it up through the organisation' (IP3, DQ, C1) varied between cases. Mechanisms for cascading quality strategy from the strategic plan to subordinate planning mechanisms at the governance level included the operational plan or a standalone quality plan. Six cases used operational plans as a subordinate planning mechanism, with three cases either or also using a stand-alone quality plan.

C3 used strategic pillar headings in its operational plan but did not disseminate specific quality priorities. C1, 2, 4, 5 and 6 placed strategic plan quality priorities in subordinate plans. A lack of cascading and therefore influence of strategic quality priorities, evident at two cases (C7N, 8) is raised by multiple interviewees at these cases and is reflected in the following comments.

> *So, the focus of the board, you wouldn't say it was strategic because we're not looking five years into the future. We're not continually going back to our strategic plan. The focus of the board is really, attending every month and listening to the exec go through the board papers and asking minutiae about how did that patient fall. (IP38, Board member, C8)*

I don't think it's [BQC] strategic… I'm hoping that it becomes so. But I don't think it's strategic, because it is just a lot about reporting some of those core KPIs. (IP33, DoN, C7N)

Pillars and priorities cascading to annual operational plans and/or stand-alone organisation-wide quality plans in cases is summarised in Table 16.

Feature	C1	C2N	C3	C4	C5	C6	C7N	C8
Operational plan present	✓	✓	✓	✓	✓	✓		
Operational plan elements include:								
• Strategic plan pillars	✓	✓	✓	✓	✓	✓		
• Strategic plan quality priorities	✓	✓		✓	✓	✓		
• Non-strategic plan quality priorities	✓	✓	✓	✓		✓		
Quality plan present					✓		✓	✓
Quality plan elements include:								
• Strategic plan pillars					✓			
• Strategic plan quality priorities					✓			
• Accreditation strategies					✓		✓	✓

Table 16: Cascading of strategic priorities in operation or quality plan

Cascaded quality priorities are often broad, as described in the previous section, allowing for a diverse range of actions to be placed against each priority. These broad strategic priorities are usually linked to specific government service agreement priorities or other external requirements. A NSW quality director indicates that quality initiatives are often driven externally, rather than by strategy, because external priorities are often 'more specific' (IP7, DoQ, C2N). Setting broad priorities within the strategic plan is viewed as practical in public sector entities to accommodate emergent external priorities. As one interviewee states,

The [departmental] statement of priorities was about 25 deliverables that we have sort of massaged into our strategic plan. But we're

> *spending so much time trying to deliver on those. We don't have time to look back at the strategic plan and say what else is in there that we should be focussing on. (IP35, CEO, C8)*

However, there is a need to better capture quality planning initiatives from internal sources, such as internal reviews or management initiatives, as explained by this interviewee,

> *We've got a big new [clinical area] strategy starting to hopefully happen. But we don't get regular reports on how that's progressing and what difference is it making and how is this place really changing. (IP21, Board chair, C4)*

At C1, C2N and C3, planning mechanisms are in place that capture and make transparent, at the corporate governance level, planned and emergent priorities. C1 has developed a planning mechanism that incorporates quality improvement priorities from multiple sources including those cascaded from strategy, those directed by external agencies, and those arising internally from risks identified, performance variation or management initiatives. The plan is dynamic and actions can be added to address risks as they arise. This enables transparency and governance oversight of all key priorities. C3 and C2N use their annual operational plan in a similar way to capture a broader range of quality priorities from different sources.

C5, C8, C7N have quality plans that capture only accreditation requirements. The failure of planning mechanisms to provide an overview of all key quality initiatives is noted.

> *Quality improvement plan, there isn't one. So, what we've done is take it down a level and said right we've got standards committees for each of the standards, let's have a quality improvement plan for each standard, because I cannot get traction at this moment you know for what is a [organisation] wide quality improvement plan. (IP22, MQ, C5)*

Planning processes generally incorporate elements of both planned, deliberate priorities and emergent priorities (Snow & Hambrick, 1980; Stiles, 2001). What is

evident in cases is a relative lack of strategic planned priorities. Quality planning is dominated by emergent priorities, either reactive in nature to internal needs or risks, or imposed by external requirements. Priorities arising from these sources are seen as being more specific and provide clear direction to organisations. Strategy dominated by emergent priorities suggest three possibilities:

- The failure to articulate specific goals is an astute management strategy to keep options open to accommodate emergent goals (Snow & Hambrick, 1980)
- Organisations do not have capabilities to identify quality improvement initiatives
- Organisation do not have the resource to address additional strategies above and beyond compliance requirements.

The evidence in this study indicates the first and third option have some merit. The awareness of and need for more specific strategic objectives in relation to quality is apparent from interviewees. However, the ability of organisations to respond to multiple priorities is limited and there is a prioritisation of externally derived quality improvement initiatives. In most cases there is no more than a symbolic nod to quality healthcare improvement priorities in the strategic plan. There is an abundance of quality priorities from regulatory bodies such as state health departments, accreditation agencies and in the case of NSW, semi-government authorities driving centralised programs of quality improvement. This creates 'priority thickets' (Dixon-Woods et al., 2013, p. 4) from which organisations struggle to find the space for additional quality priorities at a strategic level. The development of broad strategic goals allow the inclusion of these external priorities as they emerge in annual iterations of a strategic plan.

The findings reveal there is limited development and cascading of specific quality improvement priorities into planning mechanisms that are visible at the corporate governance level. The lack of specificity, while useful for maintaining flexibility to accommodate external priorities, is a barrier for strategic priorities being operationalised and seen at the board level. Other specific and pressing governmental priorities and accreditation requirements are seen to take precedence in planning mechanisms, with internal priorities being less transparent.

Processes to support cascading strategic priorities can be restated as:

- Disseminate specific strategic quality of care improvement priorities into subordinate governance planning mechanisms (quality plan/operational plan)
- Incorporate and identify significant quality priorities from a range of sources in subordinate plans (e.g. strategic, external or operationally derived).

5.3.3 Monitoring progress

A key board responsibility is monitoring strategy implementation (ASX Corporate Governance Council, 2014). Only four cases have a process for reviewing progress with strategic priorities that is visible to the whole board. Of the four, C1 and C5 (along with C4) also report on strategic quality priority progress at their BQC reflecting an articulated responsibility for oversight of quality priorities in their committee terms of reference. A summary of governance oversight of quality priority implementation at the board or BQC is shown in Table 17.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Quality priority progress reporting at board	✓		✓		✓	✓		
Quality priority progress reporting at BQC	✓			✓	✓			

Table 17: Quality planning oversight

Only half the cases report on progress with strategic priorities at the board and less than half report on progress with quality priorities at the BQC. Additional mechanisms are used by cases to report on strategy, other than formal review of plans. These included reporting on strategic pillars through structuring of directorate reports to reflect activities under the broad headings (C1, C2N) and board summary quantitative tables with KPIs selected to reflect strategic pillars (C1, C6). However, these mechanisms reflect a broad link to strategy rather than reporting back on implementation of specific priorities.

> *I haven't got really a clear picture, a clear simple picture of how that [KPI reporting] feeds into those strategic. … I know that our exec put so much effort into getting all that right. But somehow making that*

[strategy] the centre of what we do in our reporting. (IP21, Board chair, C4)

Monitoring implementation of strategic quality priorities is aided by establishing measurable priorities via KPIs. The presence of measurable quality priorities in cases is shown in Table 18.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Measurable quality priorities in strategic document								
Measurable quality priorities in subordinate plan		✓	✓		✓			

Table 18: Measurable quality priorities in planning documents

As Table 18 shows there are no measurable quality priorities in the strategic plan in cases. C4 and C5 document the need to meet or exceed external benchmarks in quality healthcare in their strategic plan but do not clarify the aim further. Only three cases have evidence of some measurable quality healthcare improvement priorities within their subordinate planning mechanisms (operational or quality plans). The value of specific, measurable quality priorities is acknowledged by several interviewees.

We'll actually [in the future] put a smart objective together around particular focus areas and that certainly is the stuff that you see in the NHS and where they've actually been very targeted around the things that they will focus on. (IP1, CEO, C1)

Alternate views are expressed by two executives who feel focussed, measurable priorities are not appropriate at the governance level.

I think the more detailed you get the more you disappear down into operational stuff and the more narrow and less useful it becomes in terms of an overall governance side of things. So really, if you're getting into that sort of level of detail you know, not see the wood from the trees. (IP12, DMS, C3)

Most cases demonstrate an understanding of the need for quality and safety priorities as evidenced by their presence in strategic plans. However, moving beyond symbolic acknowledgement and cascading measurable priorities into quality planning mechanisms overseen by the governance body is not apparent in most cases.

Key processes in the oversight of implementation of quality initiatives can be stated as:

- Develop transparent strategic, measurable quality priorities
- Periodic governance reporting on progress with priorities.

5.4 Defining quality engagement

Numerous processes that further the objectives of the two healthcare governance tasks investigated have been outlined in the previous sections. Identifying these processes provides not only a more comprehensive view of engagement but also enables levels of engagement to be assessed in each case by examining their use of these processes. Defining engagement levels in each case enables influences on engagement to be identified through comparing and contrasting the characteristics of cases with different engagement levels. Input and mediating influences on engagement are identified in this way in Chapter 6 and 7 respectively.

All key process that were identified in the dot points and tables summarised in the sections of this chapter have been included in Table 19. Engagement scores are constructed by allocating one point for evidence of a process occurring in each case and then summing the points, as outlined in Table 19.

Processes	C1	C2N	C3	C4	C5	C6	C7N	C8
Task 1 Evaluating Healthcare Quality								
1. Selecting Healthcare Quality Data								
a) Board endorsed definition of quality exists			✓	✓	✓	✓		✓
b) Measurable categories of quality exist				✓	✓			
c) Conceptual categories used to identify quality data or structure reporting	✓			✓				
d) Board calendar or schedule	✓		*		✓	✓	✓	

Processes	C1	C2N	C3	C4	C5	C6	C7N	C8
that identifies quality reports (*all board attends BQC)								
e) Detailed dashboard indicator framework exists	✓							
f) BQC calendar or schedule that identifies quality indicators and reports	✓	✓	✓		✓		✓	
g) Occasional management review of board and BQC reporting	✓	✓	✓	✓	✓	✓	✓	
h) Scheduled management review of board and BQC reporting	✓	✓						
i) Scheduled board review of board reporting	✓							
2. Quality Reporting at Board or BQC								
a) Regular quality reporting at governance level	✓	✓	✓	✓	✓	✓	✓	✓
b) Dashboard/s indicators reflecting a range of dimensions of quality	✓	✓	✓	✓		✓	✓	✓
c) Quality directorate or quality report to whole board	✓	✓	✓				✓	
d) Periodic dedicated report/s reflecting safety dimension	✓	✓	✓	✓	✓	✓	✓	✓
e) Periodic dedicated report/s reflecting appropriate and effectiveness dimension	✓	✓	✓	✓	✓	✓		✓
f) Periodic dedicated report/s reflecting person centred/acceptability dimension	✓	✓	✓	✓		✓	✓	✓
g) Periodic program/clinical area reports addressing quality	✓	✓	✓		✓			
3. Identifying Performance Variation								
Formats in main whole board dashboard (either in summary table and/or detailed indicator graphs)								
a) Provision of graphs	✓	✓	✓	✓		✓		✓
b) Provision of Trended data	✓	✓	✓	✓				✓
c) Provision of Targets	✓	✓	✓	✓		✓	✓	✓

Processes	C1	C2N	C3	C4	C5	C6	C7N	C8
d) Commentary analysing data variation	✓	✓	✓	✓		✓		✓
Formats in standalone report (examined in incident report)								
e) Summary briefing document with background, analysis of data, recommendation/summary of action	✓				✓			
f) Provision of trended data from 6-36 months	✓	✓	✓	✓	✓	✓		✓
g) Provision of control limits on graph		✓		✓	✓			
h) Provision of goals/targets				✓		✓		✓
i) Disaggregated data by facilities or programs	✓	✓		✓			✓	✓
j) Commentary analysing data variation	✓	✓	✓	✓	✓			
Other key performance variation processes								
k) Target setting rationale transparent in indicator reporting framework	✓	✓	✓					
l) Comprehensive methods of internal performance assessment against evidence-based standards	✓			✓		✓	✓	
m) Annual or periodic thematic analysis (such as incidents, patient feedback or experience)	✓	✓					✓	
n) Annual operational committee reports (addressing quality and clinical risks)	✓		✓				✓	
4. Action identification								
a) System level action usually identified in dashboard (main board dashboard)	✓	✓		✓				
b) Identification of action in stand-alone reports (examined in stand-alone incident report)		✓	✓	✓				
c) Mechanisms for follow up of major quality improvement recommendations	✓	✓				✓		

Processes	C1	C2N	C3	C4	C5	C6	C7N	C8
Sum of engagement in processes related to Task 1 (33 processes)	28	23	19	21	13	15	13	13
Task 2 Overseeing Quality Priorities								
5. Develop strategic quality priorities								
a) Pillar/s addressing healthcare quality	✓	✓	✓		✓	✓	✓	✓
b) Priorities for improving healthcare quality	✓	✓	✓	✓	✓		✓	✓
6. Operationalising quality priorities								
a) Mechanism for cascading strategic priorities at governance level	✓	✓	✓	✓	✓	✓	✓	
b) Subordinate planning mechanisms contain cascaded quality priorities	✓	✓		✓	✓	✓		
c) Planning mechanisms visible at governance level incorporates quality initiatives from all sources	✓	✓	✓					
7. Monitoring progress								
a) Measurable quality strategies at a governance level		✓	✓		✓			
b) Regular reporting on progress with quality strategies at a governance level	✓		✓	✓	✓	✓		
Sum of Engagement in Processes related to Task 2 (7 processes)	6	6	6	4	6	4	3	2
Total: Sum of engagement in both tasks (40 processes)	**34**	**29**	**25**	**25**	**19**	**19**	**16**	**15**

Table 19: Engagement scores

Engagement scores developed in this study are an indicator of engagement to broadly differentiate cases of different engagement levels. From the 40 processes identified, cases vary in undertaking between 15 to 34 of these processes. Cases are categorised as high or low engagement based on their score as shown in Table 20.

High engagement score (21-40)	Low engagement score (1-20)
C1 (34)	C5 (19)
C2N (29)	C6 (19)
C3 (25)	C7N (16)
C4 (25)	C8 (15)

Table 20: Engagement levels

The number included in the nomenclature for the cases indicates their relative position on engagement scores, with C1 indicating the highest level of engagement and C8 indicating the lowest score.

Engagement scores and the resulting engagement categorisation reflect the activity and transparency of these processes at a corporate governance level at each case. Some of these processes may be occurring at operational levels of an organisation but are not transparent at the governance level. There is evidence of well-developed operational level quality processes in place at a couple of cases (C7N, C6) but these did not come to the notice of or involve the board.

5.5 Chapter 5 Summary

This chapter has refined the understanding of effective engagement in governing healthcare quality. The taskwork of board and management in healthcare quality governance was examined in this chapter using two key governance tasks. The argument has been made in this thesis that engagement in healthcare quality is complex and evidence has been provided of a range of processes required to effectively undertake taskwork. This is a more comprehensive view of governance taskwork than has previously been provided. The chapter also demonstrates variable engagement in these processes, as seen in the engagement scores. This confirms the importance of this taskwork category being included in the framework as a mediator of governance effectiveness.

This chapter broadens the understanding of the task of evaluating healthcare quality from the narrow focus on the presence of dashboards and scorecards to a broader range

of processes. The disparity in approach to evaluating healthcare quality at cases, reflects the extent to which a thoughtful approach to data selection, data analysis and monitoring action was undertaken. Cases seeking information to provide insight into system level issues and action to inform quality improvement, engaged in a number of additional processes not previously discussed in the literature.

Generally low levels of engagement in processes related to the task of overseeing quality priorities were observed including making transparent specific, internally derived planned and emergent quality strategies. While broader strategies allowed the incorporation of emergent external priorities, interviewees identified the lack of, or in some cases, the lack of visibility, of high-level but internally developed measurable strategies to drive specific initiatives for quality improvement.

Governance engagement in healthcare quality has been redefined in terms of these more detailed taskwork processes. Many of these processes are initiated or undertaken by management. This chapter highlights that it is important how well these tasks are undertaken. Healthcare quality tasks consist of a number of processes that all contribute to the effective achievement of the task objective. When important processes are omitted the ritual act of governance is satisfied but the objective of the task may not be met. Boards and managers need to differentiate between the accepted customs and rituals of governance from effective practices that ultimately support the achievement of governance responsibilities.

In this chapter, cases were categorised as having high or low engagement level according to their engagement in processes related to two healthcare governance tasks. Factors influencing engagement in taskwork are addressed in the next two chapters.

Chapter 6 Inputs Influencing Engagement

6.1 Introduction

This chapter addresses the second research question, what factors influence engagement in governance processes, by testing the relevance of constructs presented under the input heading in the conceptual framework (see Figure 6). Engagement was redefined in the previous chapter through identifying 40 governance processes related to two healthcare quality tasks. An engagement score was constructed, based on evidence of processes undertaken, to give an indication of the strength of engagement at each case. Cases were then allocated to a high or low engagement category based on the score. Input factors found to influence engagement are identified, in this chapter, through comparing and contrasting cases with different levels of engagement.

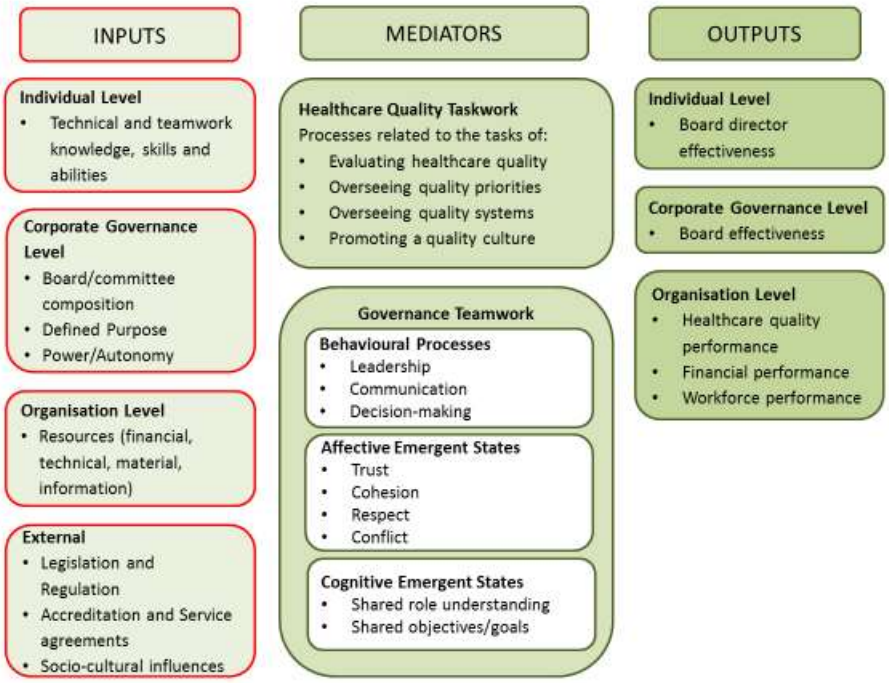

Figure 6: Input constructs in the conceptual framework

Input factors from the framework were initially examined through thematic analysis of documents, interviews and BQC meeting observation at each case as described in Chapter 4. The evidence from the different data sources is integrated in this chapter to

identify relevant inputs. Data analysis provides rich evidence about the influence of input factors on engagement.

To contain the level of description in this chapter, C1 and C8, reflecting high and low engagement level cases respectively are referred to frequently to highlight and contrast influential constructs. Other cases are referenced to highlight a pattern among cases or to explore a construct absent or less visible in C1 or C8. The inputs influencing engagement are either constructs identified in the framework and found to be relevant or those that emerge through the data analysis.

This chapter sequentially describes individual input constructs, or antecedent factors, operating at the individual, corporate governance, organisation and external level. Healthcare and governance KSAs are found to be important engagement influences along with greater board members' exposure to quality discussions via the BQC. CEO background is found to influence executive structure which in turn influences the degree to which there is a quality focus at the governance level. Evidence emerges as a key external input that acts to shape engagement in governing healthcare quality in cases. The chapter concludes by finding most of the constructs in the input category of the conceptual framework are relevant in the governance context. Evidence and management hierarchy emerge as important additional constructs influencing governance engagement.

6.2 Cases one and eight

C1 and C8 are highlighted frequently in this chapter, as a mechanism to compare and contrast factors influencing engagement, as they represent cases that differ in engagement levels. This mechanism is used to limit repetitive description of findings found at multiple cases. Detailed evidence from all cases is presented in the tables in this chapter and in the text from relevant cases where necessary to highlight findings not evident in C1 or C8. A description of C1 and C8 is provided below.

C1 is a large hospital network located in Melbourne, Victoria that received the highest engagement score of 34. The organisation has been acknowledged by peers and through awards to be a leading health service. C1 has a stable executive team and board leadership positions. The organisation routinely meets and at times exceeds

departmental performance requirements and accreditation compliance, and demonstrates innovation in quality healthcare. The executive and board have a clear focus on excellence in patient-centred care.

C8 is a small rural hospital located in Victoria and has the lowest engagement score of 15. The organisation has a turbulent history, over the four years prior to the study, with a succession of CEOs and changeover at the senior management level, including the senior quality staff member. The organisation was, in the year prior to the study, under performance-watch by the state department of health for financial reasons. The governance focus over recent years has been on finance and meeting accreditation requirements of new national standards introduced in 2013.

Inputs under the individual, corporate governance, organisation and external level found to influence engagement in healthcare governance processes, through a review of all cases, are highlighted through reference to these two cases in the following sections.

6.3 Individual level inputs

Influences on engagement arising from individual characteristics of board members and senior managers are outlined in this section. Variations in individual knowledge, skills and abilities (KSAs) can exist due to differences in background, training and experience. An understanding of healthcare systems, governance and data interpretation emerge as important KSAs from the interviews and are addressed in the following sections.

6.3.1 Clinical and healthcare knowledge, skills and abilities

The boards in Victorian cases are made up of non-executive board members, with the addition of some local clinicians in NSW. The presence of clinical skills at the board has been identified in the literature as potentially conferring a benefit in terms of the knowledge and experience clinicians can bring to the discussion of quality (Chambers et al., 2018). A clinical background is defined, in this study, as having a qualification in medicine, nursing or allied health, irrespective of whether the person is currently practicing.

At C1, the highest engagement case, 3 (22%) board members have clinical backgrounds, as do all three leadership positions of interest in this study, namely the CEO, board

chair and BQC chair. This contrasts with C8, a low engagement case, where only one (10%) board member and none of the three leadership positions have clinical backgrounds. CEOs and board members with clinical backgrounds, at the time of the most recent board paper in the document review, are shown in Table 21.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Number of board members	9	11	8	8	8	8	10	10
Numbers of non-executive board members with clinical background	2	3	2	1	3	2	2	1
Number of local clinician board members (NSW only)	0	2	0	0	0	0	3	0
Total number of board members with clinical background (non-executive and local clinicians)	2	5	2	1	3	2	5	1
Proportion board with clinical background	22%	45%	25%	12.5	37.5%	25%	50%	10%
Board chair with clinical background	✓				✓			
Board Quality Committee (BQC) chair with clinical background	✓	✓	✓		✓	✓	✓	
CEO with clinical background	✓		✓			✓	✓	

Table 21: Board member and CEO background

Having more clinical background board members does not necessarily relate to higher engagement scores as can be seen from Table 21. C5 and C7N both have relatively high proportions of clinical background board members, but have low engagement scores. However, greater numbers of clinical background board members increase the likelihood of having designated board leaders with clinical backgrounds. Designated board leaders, with direct responsibility for governing healthcare quality as part of their

leadership responsibilities, include a board chair and a BQC chair. Excluding NSW cases (C2N and C7N) where appointed clinicians cannot be the board chair, it can be seen from Table 21 that Victorian cases with one or two board leadership positions occupied by people with clinical backgrounds (C1,3,5,6) have high proportions of clinical background board members. This contrasts with C4 and 8 with no clinical background board leaders and low proportions of clinical background board members. The proportion of clinical background board members is a factor in determining whether board leadership positions that can influence healthcare quality governance are occupied by clinical background board members.

Two board chairs and six BQC chairs possess a clinical background. This is seen as conferring a benefit in terms of leadership and direction provided to other board members, as explained below.

> *There's a real content issue that's really important in boards and we've been incredibly lucky in [hospital] to have had a board that's, to have a board chair such a leading [clinician advocate] has been enormously beneficial. (IP3, DQ, C1)*

Clinical background board members are important in 'lead[ing] the discussion' (IP25, Board member, C5) and asking 'the right questions' (IP22, MQ, C5). They also broaden the perspective of non-clinical background board members and counter a tendency to stick to areas of comfort.

> *We had a presentation at telemedicine of, you know, the use of robots in health services and we said this is fantastic. We'll have robot nurses and, you know remotely monitored wards where, you know, the nurse just sitting at a station with these screens and then. Anyway, the other board members at the time who were also from a finance background were saying "oh, you could make it really efficient, imagine". I think it was (clinical background board chair) who said "who holds the patients hand when they are dying?" And so, that was a very polite backhander to say the money is important but it's about the patient. That was my sort of steep learning. That was board meeting no 1. That was a good*

> *induction. So, that why it's important to have a mix of non-clinicians and clinicians on the board. (IP5, Board member, C1)*

A clear distinction is made between clinical backgrounds that enable a broad understanding of the overall workings, systems and language of complex healthcare organisations, the 'business of health' (IP23, DoN, C5), and technical knowledge that clinicians bring. Board members with technical clinical KSAs, are perceived at times, by a few interviewees, to be susceptible to a 'natural bias' (IP7, DoQ, C2N). The following interviewee explains, 'doctors [on the board] become very… doctor-centric because all they know and care about is … their own little empires (IP24, medical background board member, C5).

Clinical background board members who possess broader knowledge of healthcare systems could, as interviewees explain, 'educat[e] the other board members about the system' (IP7, DOQ, C2N) and 'how everything works' (IP28, MQ, C6). Broader healthcare KSAs are valuable at the board as discussed by this interviewee.

> *If you don't have people on the board that have a really good understanding of, you know how, how a hospital works. And it is that simple example I gave you about reducing the bed stays by looking at quality outcomes. You know, it's going to drive your dollars. You know, that, sometimes is a revelation to people without that knowledge. (IP4, BQC chair, C1)*

The challenge for board members without experience of hospital and healthcare systems is described,

> *I suppose having not worked in the health sector at all and also having not worked in the public sector at all. So, I didn't have either of those two backgrounds. So, I think that probably I was a fair way behind. And then it's just such a complex business that we are in that it has taken a long time to get to a position where I feel more comfortable. (IP20, BQC chair, C4)*

At C1, both clinical background board members, the board chair and BQC chair, have broad, deep experience of the healthcare system through senior positions in the

healthcare industry, and governance KSAs through holding various chair positions at other hospital and health-related institutions. In contrast, the clinical background board member at C8 worked as a hospital clinician and possesses a technical focus in healthcare knowledge, evident in the observations of the BQC meeting.

CEO background is also seen as an important influence on board and management engagement in healthcare quality. Interviewees acknowledge that different approaches and emphasis could occur with CEOs of a similar background due to a 'set of values or beliefs' (IP1, CEO, C1) or the 'environment has sort of made it [a particular issue] more of an issue' (IP32, DQ, C7N). However, a clinical background and a 'broad deep experience across the system' (IP15, Board chair, C3) is generally seen to be an advantage. This is described by one interviewee,

> *Having a clinical CEO, I think that's absolutely vital. I just see such a huge difference in approach for someone that actually knows what happens on the floor and have been there and done that. They're not unrealistic in their expectation. They know how it works. They know what we should be doing. And the load is sort of spread across more people, it's not just (Director of Quality) this is your job. It's everybody. You know, this is all of your, quality and safety is everyone. (IP13, DQ, C3)*

Clinical background CEOs are seen to have an understanding of patient harm that contributes to them promoting a governance culture of constant unease with the current state of quality and encouraging ongoing 'vigilance' (IP11, CEO, C3). The following interviewee highlights this,

> *(Former non-clinical CEO) saw himself as an expert on governance and yeah that's fine. But you can't you can't be a total expert unless you're a clinician. You have to have gone through that dreadful thing of having made a mistake and harmed a patient and every clinician alive has done that. To realise, to be able to try and sort things out and realise, you know, what's reasonable to expect of someone and what's not. You, you have to have been part of the system. (IP17, DMS, C4)*

Just as board members are seen to have a bias in areas they are familiar with, CEOs are similarly seen to gravitate towards their areas of comfort.

> *Some CEOs are very focused on the business side of the house, making the budget and don't have a clinical background. In that circumstance, particularly if making budget is a problem, then they can become very focused on that and not as responsive as they need to be to clinical issues. (IP17, DMS, C4)*

The success of non-clinical CEOs in engaging with healthcare quality is perceived to be related to the extent to which they are aware of, and made deliberate attempts to, overcome their natural bias. The following manager discusses the adjustments made by a financial background CEO.

> *[CEO] is actually quite focussed on it [healthcare quality] and there's a reason for that. Having, we both sort of acknowledge that coming from a clinical background can be an advantage and therefore it's part of your DNA. For [CEO], he sees that it's an area of business, because he's come from a non-clinical background, which he intrinsically might be at a disadvantage. So, because of that he does pay a lot of attention and gives it a lot of focus. (IP8, Manager, C2N)*

A similar view is expressed when the following clinical CEO gave advice to a non-clinical executive director on becoming a CEO in the future.

> *You'll need to make sure that you've got the most fabulous director of medical services and director of nursing. And you'll need, the way I interrogate you about finance, because I've learnt to be good at it over the years only by virtue of taking a ruler and saying 'But why, but why, but why'. (IP11, CEO, C3)*

Board leaders and CEOs with clinical backgrounds, providing knowledge of healthcare and hospitals systems, are seen to influence governance engagement in healthcare quality.

In summary the study finds that a greater number of board members with clinical KSAs increases the likelihood of having designated board leaders with these skills. Board leaders with these skills are seen as an advantage in focussing discussion on quality healthcare, if clinical skills are combined with broader healthcare knowledge and experience. Similarly, clinical background CEOs are seen as beneficial in promoting a quality focus. However, financial background CEOs can compensate for clinical KSA deficits if sufficiently aware of their potential bias and actively seeking to promote a quality focus.

6.3.2 Governance and data analysis KSAs

Many interviewees acknowledge that the contribution of clinical background board members need to be 'balanced by those other voices' (IP23, DoN, C5). 'A mix of clinicians and non-clinicians' (IP5, Board member, C1) bring a valuable 'combination of the skill sets' (IP23, DoN, C5). Governance skills are perceived to be particularly important. As one interviewee notes, 'just because they're clinicians, they don't necessarily ask the right governance questions' (IP28, MQ, C6).

Interviewees feel board members with governance skills bring a set of fundamental 'principles' (IP9, Board member, C2N) and 'a methodology and a process' (IP33, DoN, C7N) they can apply usefully in any governance context. Bringing 'the right discipline to it' (IP17, DMS, C4) irrespective of professional background is emphasised.

> *So [board member] for instance is finance. He's actually the chief executive of a [commercial finance organisation]. So... I think, has a very keen understanding of governance generally speaking, from a corporate governance perspective. So, I think that's a great skill set he brings to the table. (IP7, DQ, C2N)*

The majority of board chairs (n=5) have previous governance experience at another organisation, but this is less often seen with BQC chairs (n=3). The challenge of taking on a board leadership role with minimal governance experience is acknowledged by several BQC chairs. Two board chairs who were selected on the basis of their clinical background comment,

> *Well I'm not very good at chairing meetings but the clinical governance stuff didn't worry me as much as chairing the actual meeting. (IP29, BQC chair, C6)*

> *I didn't have a clue. I hadn't done the company directors course. I didn't, I was completely naive "I'd like you to chair the [committee]" and I said "oh ok" and then I thought "oh my god". (IP10, BQC chair, C2N)*

Another board member, without previous governance experience, discusses in negative terms his short preparation for the role of board chair; 'first meeting I sat there, the second meeting I ran it' (IP24, board chair, C5). The value of governance skills in effective chairing of BQC meetings is evident in the observations. The C1 BQC chair with considerable governance experience could control, direct and focus BQC discussion. In contrast, the BQC chair at C8 with less governance experience allowed conversations to drift into operational areas and exerted less control over the meeting (see Chapter 7, section 7.2 for more detail).

Data analysis skills are also identified by several management interviewees as essential for board members and managers at the governance level and enable effective 'challenging of the data' (IP27, DQ, C6). Skills in understanding variation, statistical significance and complex graphical data are seen as advantageous, as explained,

> *If I present something in process control they kind of look at it and go "What is this". I don't know if you've seen the VLAD charts. Imagine what they look like. I have trouble understanding them. (IP22, MQ, C5)*

Differences in management skills in this area are evident in the sophistication of reporting content and formats used to present healthcare quality data as outlined in Chapter 5. Interestingly, no board members mention the need for these skills. This low awareness of the need for these skills is reflected in lower level of engagement in analytical processes of identifying performance variation discussed in Chapter 5.

In summary, governance KSAs are an essential factor in promoting engagement in governance processes. No direct mention is made of teamwork KSAs such as task coordination, communication or conflict resolution, by any interviewees. However,

these skills are implied in the descriptions of governance skills. Data analysis skills are also seen as important, although awareness of the need for these KSAs is less apparent among board members.

6.3.3 Developing KSAs

Board members saw time as important in overcoming knowledge deficits, 'after nearly six years I feel like I can contribute better' (IP20, BQC chair, C4). As one board member explains,

> *You should be ready and 100% trained and understand everything as a board director but the reality is it does take time to get your head around a complex place like this. (IP25, Board member, C5)*

The time taken by some board members to gain an understanding of the health sector and quality issues indicates the role that processes of orientation and skill development play in promoting earlier engagement.

The degree to which skill development is seen as a government, organisation, board or individual board member responsibility varies between cases. At C1, the responsibility for skill development is seen by management to be an organisational responsibility.

> *We have what we call the capability model and we apply that right across (health service) from board members to members of staff. What does it take for them to be capable of doing the job that they need to do and what information do they need and what skills and training in order to be able to do the work that they need to do. (IP3, DQ, C1)*

In contrast at C8, the responsibility is seen as belonging to the board as this interviewee observes,

> *The board needs to take ownership of assessing the results [of the skill matrix] and agreeing on where they want to develop their skills, what are their priorities for developing their skills. Not leave it to me to tell them, because they won't listen. (IP35, CEO, C8)*

Other interviewees see it as an individual responsibility 'I've taken myself to company director's course and other things' (IP10, BQC chair, C2N). The individual approach relies on personal motivation.

> *If [board members] are diligent and there are enough … related things that people can go to and a lot of them do attend them. So, they are getting exposed to other quality things. (IP34, BQC chair, C7N)*

Differing organisational responses to building board skills are highlighted through examining board orientation. The content of organisational-run board orientation programs at cases is outlined in Table 22.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Orientation program for new board members provided by organisation	✓	✓	✓		✓	✓	✓	✓
Orientation provides content specific to quality and safety	✓		✓			✓		
Orientation includes separate meeting with senior quality staff	✓	✓	✓					

Table 22: Organisation initiated board orientation

At C1-3, an individual meeting with a senior staff member responsible for coordinating healthcare quality is provided, in addition to a standard program of orientation. This creates an opportunity for comprehensive healthcare quality orientation.

> *We'll have like a two-hour session, I think it was last time, and I'll do things like the national standards and our incident reporting system and how we manage all that sort of things under my area. And then we go through all of the graphs and what the reports look like for the board and we'll pick up the last month's board minutes papers and go through them with them. (IP13, DQ, C3)*

The director of quality going 'through all of the reports, the structural stuff and the mechanisms' is helpful in a board member 'hav[ing] a handle on what's there and why it is there' (IP9, Board member, C2N).

At C1, the meeting with the director of quality includes 'induction around you know quality care' and 'all the information around you know the patient experience, the patient journey' (IP4, Board member, C1). Orientation includes 'tour[ing] the sites and engag[ing] with the staff' (C1, IP5, Board member). Exposure to healthcare is promoted through early membership of the BQC, 'all new board members, the first place they start is on the quality committee. That's where they hear about the business' (IP3, DQ, C1).

The impact of the structured approach to healthcare quality orientation at C1 is described as follows,

> *That induction or that exposure for board members as they come on has a real impact. And you know you hear them talking it up and up and up and you think you've got the message. (IP4, BQC chair, C1)*

Structured approaches to healthcare skill development, at C1 and C3, include a clear message regarding the ongoing availability of senior staff to provide information or answer questions. This is reflected in interviewees comments, 'they always have our numbers and things like that so they can contact us (IP13, DQ, C3) or 'I'm available…if they have any requirements for any of that, sort of regular orientation' (IP3, DQ, C1). In contrast, at C8, board member orientation includes a facilities tour, the provision of three previous months' board papers and meetings with each executive director, but not the quality manager.

Orientation specific to quality for new board members is not yet apparent at the local level in NSW cases as comprehensive centralised departmental programs of board orientation had been made available upon the establishment of boards in 2011, which included clinical governance.

The development of governance KSAs at the organisational level is less structured and tends to occur through whole of board development activities. Different levels of

engagement in processes of skill development are observed. At C1, a manager reports that 'we provide some ongoing training for the board whether it be in risk management or patient experience' (IP3, DQ, C1). At C8, a board member remarks, 'we have this thing on the agenda every now and again, board education, and we sort of justify skip by it and go on to the next thing' (IP38, Board member, C8).

The discussion of skill development is not limited to board members, with managers frequently identifying the need for skill development in quality staff.

> *I think it's actually a real problem with the skill mix at my level and I'm not being critical. I don't think directors of quality actually understand systems and what it means to have all those components in and what our role really is, um, and partly because I think we just keep doing what we've done. (IP22, MQ, C5)*

The initial training of most quality executives and managers is as a clinician, which generally does not include quality improvement theory. Many learnt their skills 'on the job' (IP18, MQ, C4). One interviewee explains,

> *I sat next to the office, literally the office next door to me, was the director of clinical governance when I was the [clinical program] director. And so…I could see what he was doing. And got to know his role and sat in meetings where clinical governance was a discussion point and got exposed to it because I worked at a senior level. But I didn't do any particular training. (IP32, DQ, C7N)*

This absorption of skills is supplemented in some instances with post-graduate qualifications, short-term training and conferences.

> *Basically, I've had one of the best teachers in the world. I've had [DMS]) to teach me so. So, a lot of it came from that. But I've also done further study, quite a lot of further study…I did a masters in health management. I did, some of my subjects were around quality improvement, statistic, biostatistics and epidemiology. (IP18, MQ, C4)*

At C1, the director of quality has extensive experience as a clinical stream manager and multiple executive roles. The organisation also supports attendance at local and international conferences and study tours to foster understanding of best practice quality improvement approaches. At C8, the quality manager has some management experience, but has never previously held a quality position and 'struggled to get training or support' from external sources and felt 'a lot of wasted time' was spent by her trying to understand quality systems.

In summary, cases are seen to vary in their provision of, and comprehensiveness of, board member orientation. More comprehensive programs are seen at more highly engaged cases and ensure content on healthcare quality. Interestingly, the development of governance skills is less evident and less remarked on by interviewees despite the importance placed on these skills seen in 6.3.2. Through exploring individual level KSAs, an important governance process of board orientation for both boards and managers is identified. While this is not an input, in the sense that it is an antecedent factor, it is a process that needs to be added to the taskwork section of the conceptual framework.

6.4 Corporate governance level inputs

Factors acting at the corporate governance level, involving board and senior management, to influence governance engagement in healthcare quality are examined through analysing governance composition, meeting time, BQC terms of reference and power.

6.4.1 Governance composition

Board composition differs between the two states due to legislation that requires boards in NSW to comprise local clinicians and prevents this in Victoria. At C2N, a staff clinician is the BQC chair and this is seen as a source of tension '[board member] actually works at one of the hospitals so she's challenging the general manager of which she is sort of [a] service provider at that hospital' (IP7, DoQ, C2N). Despite this tension, local clinician appointments on the board are seen as a 'kind of a benefit. It's kind of a bonus to be internal' (IP9, Board member, C2N). Local clinicians are seen to have valuable insider knowledge, as described in knowing 'where the bodies are buried' (IP10, Board member, C2N). Potential conflicts of interest are perceived to be managed

and the only reservation expressed is a tendency for clinicians to be drawn to areas of professional concern related to their clinical practice through 'an unconscious bias' (IP6, CEO, C2N).

A management interviewee, at C7N, sees clinician bias as 'a problem' with staff board members bringing 'a particular view and particular interest' (IP33, DoN, C7N). Another manager feels staff board members 'sit in on committee with two hats…so, when they're there it's a little bit hard to differentiate if they're talking as a board member or as [a clinical leader] (IP32, DQ, C7N). This is apparent at the observation of the C7N BQC meeting where two local clinician board members are not visibly active in undertaking their governance role. The influence of clinician board members on engagement is hard to determine, given their presence in only two cases. However, it is apparent that their governance role needs to be clearly defined and delineated from their everyday work.

BQC composition varies between cases in terms of number of board members and type and number of senior managers attending. CEOs regularly attend in all cases, along with the director of nursing or clinical services, director of medical services (at all 7 cases with this position) and the most senior staff member responsible for quality attends in all cases except C8. The entire senior executive team attends at C3 and C4. The composition of the BQC observation meeting at each case is shown in Table 23.

BQC Feature	C1	C2N	C3	C4	C5	C6	C7N	C8
Total number of attendees	16	13	13	14	17	6	39	12
Number of board committee members present	4	1*	9	3	4	2	4	3
Number of board members attending as observers	0	0	0	0	3	0	0	0
Total number of board members attending	4	1	9	3	7	2	4	3
Proportion board members	25%	7%*	69%	21%	41%	33%	10%	25%

*One board member an apology

Table 23: Profile of BQC attendance at observation of BQC meeting

The striking feature of Table 23 is the 39 attendees at the observation of the C7N BQC meeting, of which four are board members. It was not easy to discern who the executive

and non-executive board members were among the large gathering of clinicians, managers and executive directors and they were not introduced. The CEO perceives the size of the BQC meeting as a strength 'if you want really good engagement you don't have three people there' (IP31, CEO, C7N). However, an executive felt 'there's not much input' (IP33, DoN, C7N) from non-executive board members. Input from staff board members is also limited as described by a manager, 'other two people [executive board members] that are on the council [BQC] are both staff so … there's no challenging' (IP33, DoN, C7N). The BQC composition at C7N works against board member engagement. A similar sentiment is expressed at C5, the second largest meeting, where a board member feels 'vastly outnumbered [by staff] compared to other board [committees] (IP25, Board member, C5) and goes on to explain the impact,

> *So, you do feel a bit overwhelmed by the numbers. But again, it doesn't bother me, but I can just feel it's a very different dialogue so they [clinical managers] have their own conversations a lot and it's just making sure that, you feel like you've got to get your voice in there as well. (IP25, Board member, C5)*

C3 is the only case at which the number of board members at the BQC exceed the number of managers as all board members are required to attend. This is a deliberate strategy to ensure a stronger board engagement with quality, as explained,

> *We used to have two reps from the board that sat on the quality committee and it didn't get enough representation at the actual board meeting. They just flipped through the minutes like you do with the whole raft of meeting minutes at the end of the meeting and it didn't get the airplay that it needed. (IP13, DQ, C3)*

A sense of not being able to pick up a comprehensive picture of quality from the minutes or 'getting it second hand through a report' (IP15, Board member, C3) is raised by several interviewees.

> *If you just read the minutes, if you don't go to these meetings how do you really know what's going on…We encourage everyone to come here…You can't put everything in writing. (IP24, BQC chair, C5)*

In summary, the balance of board members to staff at BQC meetings is seen to influence the opportunity for board member engagement in healthcare quality discussions. While staff who are board members, at the NSW cases, appear at times to struggle with their dual role, the influence of local staff on boards cannot be determined from these cases alone.

Six of the cases included consumer or community representation as part of the membership in the BQC TOR. Two of the cases (C1 and C4) had community representatives that were also members of the consumer advisory committee. In the case of C1 this was to ensure the representatives acted as a conduit for information from the community advisory committee. Three cases had vacancies in these positions at the time of the BQC observation indicating the challenge of finding and maintaining consumer representation.

Interviewees at C1 remarked on the contribution of consumer representatives with skills and experience in healthcare and the 'value that they have added' (IP1, CEO, C1). There was a perception that organisation needed to be sufficiently mature to engage effectively with consumer representatives as discussed by the following CEO.

> *The timing has been right to then be able to bring the consumers much more into the governance process. If it hadn't happened years ago that would have been we wouldn't have been ready. The organisation wasn't ready (IP1, CEO, C1)*

At C4 the experience of a consumer representative on the BQC was less productive. A report from C4 regarding a recently resigned consumer representative on the BQC indicated that she had 'felt out of her depth' and the information at the committee was 'not easy to understand' (C4 Minutes of BQC meeting, March 2017). This highlighted the need for organisation to consider 'what is the role of the consumer in this room? And how are we going to actually manage that' (IP21, Board member, C4). While the potential contribution of consumers to effective governance is clear from the findings. it is evident that organisations need to approach consumer recruitment and support in a considered fashion to achieve the best outcomes. As the following interviewee states 'having a consumer that's really got the skills and then create the opportunity for them to be a valuable part of the dialogue' (IP33, DoN, C8).

6.4.2 Exposure to quality

Board exposure to quality discussions through direct contact with the BQC is a key influence on engagement emerging from the data analysis. Time allocated for BQC meetings each year and numbers of board members attending at cases are shown in Table 24.

	C1	C2N	C3	C4	C5	C6	C7N	C8
BQC meeting frequency/year	4	10	10	10	4	4	6	6
Espoused BQC duration (hours)	2	2	1	1	1.5	1	1.5	1
Total espoused BQC hours/year (hours)	8	20	10	10	6	4	9	6
Board member numbers from terms of reference	4	2*	9	4	3	2	4*	3

Table 24: BQC meeting time

The total time allocated per year to the BQC varies from 4 hours/year at C6 to 20 hours/year at C2N with the median time being 8.5 hours/year. A measure of board exposure is developed based on the total BCQ hours per year multiplied by the number of board members attending the meeting. The board exposure results are shown in Figure 7.

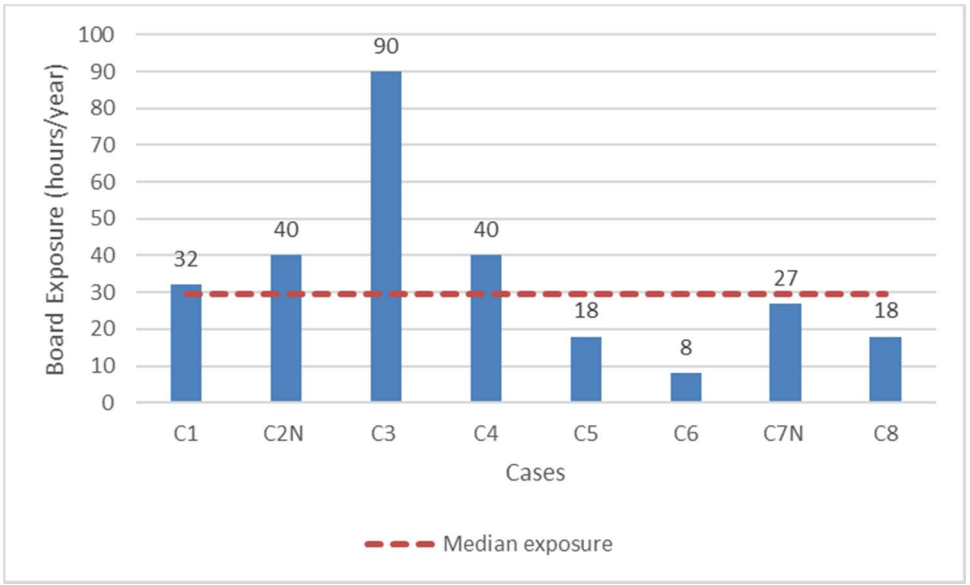

Figure 7: Board exposure to BQC

Figure 7 highlights the range of BQC exposure from 8 hours/year at C6 through two board members attending quarterly, to 90 hours/year at C3 reflecting the monthly attendance of the whole board. The median exposure of the board to the BQC is 29.5 hours. The four most highly engaged cases all have exposures above the median compared with the scores of the four lowest engaged cases all below the median.

Notable among cases with higher engagement scores are deliberate initiatives to increase board member exposure. Board members at C1 are started on the BQC as their first board committee to foster understanding of quality issues. At C3, all board members are exposed to quality through whole board BQC attendance. Similarly, at C5, board members are encouraged by the chair to sit in as *ex officio* BQC members, 'I've told people at board level if they have the time to, have the time come along to [BQC], they nearly all come' (IP24, BQC chair, C5).

In contrast, C8 have only recently had their BQC chaired by a board member and have limited hours per year for meetings. Two BQC meetings were cancelled within the period of document review and were not rescheduled. A board member notes, 'I've got a big problem with that committee, because we're having our first one today for six and a half months' (IP38, Board member C8). Similarly, C6, a low engagement case, has limited board exposure via a one-hour meeting, four times a year with two board members attending. At C6, the quality director feels 'I honestly don't think that's right…four hours a year to do quality, to do governance' (IP27, DQ, C6). C6 states in their BQC TOR that all board members are eligible to attend the BQC as *ex officio* members, however this is not enacted at any BQC meetings in the 12-month document review period.

In summary, board member exposure to healthcare quality discussion through the BQC is an important influence on engagement. Greater number of board members and/or greater time at the BQC, to discuss and undertake tasks of healthcare quality, is apparent at more highly engaged cases.

6.4.3 Purpose, roles and responsibilities

BQC terms of reference (TOR) document composition, board exposure and the work to be undertaken in governing healthcare quality as expressed in the purpose, roles, specific tasks and membership. Most cases identify the BQC purpose in procedural terms addressing the committees need to inform the board, rather than strategically in terms of improving healthcare outcomes. The broad roles of the BQC are articulated under various headings such as objectives or roles and are summarised in Table 25.

Stated Role	C1	C2N	C3	C4	C5	C6	C7N	C8
Monitor quality performance	✓	✓	✓		✓		✓	✓
Improve quality performance	✓	✓		✓	✓		✓	✓
Timely response to issues	✓		✓		✓			✓
Manage risk					✓			✓
Oversee quality systems	✓	✓	✓		✓	✓		✓
Promote quality culture							✓	
Oversee quality planning and priorities								
Foster innovation	✓		✓		✓			✓

Table 25: BQC roles in TOR

While the boards' roles in monitoring and improving healthcare quality performance and overseeing quality systems are well documented among most cases, there is little acknowledgement of their key role in tasks of quality planning or leading a quality culture. Among Victorian cases, the particular emphasis on board roles articulated by C1, C5 and C8 mirror board roles expressed in Victorian state legislation aimed at larger hospital networks, such as C1 and C5.

Presentation of detailed tasks or responsibilities in the BQC TOR varies in terms of grouping and level of detail. The number of responsibilities cited by organisation range from 5 (C2N) to 27 (C1) and all include tasks related to evaluating healthcare quality and most (n=7) to overseeing quality systems. While all cases identify responsibilities in relation to the process of reporting quality data, as part of the task of evaluating healthcare quality, only half articulate the need to identify underperformance and

monitor the implementation of actions. This reflects the findings on greater engagement in processes of reporting quality data, as opposed to identifying performance variation and action identification under the task of evaluating healthcare quality (as presented in Chapter 5).

Three cases (C1, C4, C5) acknowledge a specific responsibility to oversee quality planning and three acknowledge leading a culture of quality through involving staff in quality activities (C1, C3, C5). While seven cases address the need to review the committee terms of reference only five cases address the need to undertake a regular committee evaluation.

The findings show that of the two key tasks of healthcare quality governance of interest in this study, the task of overseeing quality priorities is given little prominence in TOR compared to the task of evaluating healthcare quality. This underrepresentation of quality priority taskwork in the BQC TOR is reflected in the broad lack of engagement in effective processes to oversee quality priorities noted in Chapter 5. Similarly, some processes of evaluating healthcare quality omitted in TOR reflect the lesser engagement in these processes noted in Chapter 5. This suggests the articulation of responsibilities in TOR may play a role in influencing taskwork undertaken at the governance level. Furthermore, the mirroring of responsibilities from legislation in TOR, seen at a few cases, indicates the influence of external sources in understanding governance responsibilities.

6.4.4 Power

Power is a construct included in the conceptual framework, at the corporate governance level, to describe the formally articulated power and autonomy of boards to make decisions within an organisation. This input construct, derived from the team literature, is found in this study to be less relevant in the corporate governance context. The institutional decision-making power of boards and their committees is firmly enshrined within the conventions of corporate governance. Board powers are formally expressed in legislation, constitutions and terms of reference. The findings show that all cases had constitutions and terms of reference expressing the formal powers of boards and board committees. In addition cases operate under legislative frameworks that articulate their powers. These formally expressed powers do not vary between

organisations in the same way that the power of different types of teams may vary within organisations. Power as an antecedent input factor is therefore less relevant in the governance context.

Note that the discussion of formally assigned power as an input into decision making is separate from the discussion of the power or influence of executive or non-executive board members in the conduct of governance. Power or influence differentials are evident at the individual level. CEOs are central to the exercise of power and influence at cases. At some cases, CEOs ensure the distribution of power to executives and board members through the creation of hierarchical structures and support of governance processes. At C1 and C3, the CEOs sought to create hierarchical structure that increase the engagement of executive quality staff in governance (see section 6.5.2). At C7, the CEO retains power, through personally chairing the BQC meeting, which reduces the power and control of board members. Board chairs are also seen to be powerful in promoting (C3 and C1) or limiting the discussion of quality (C4). The influence of power on governance engagement, acting through recognised governance leadership roles, are discussed further in Chapter 7. Individual power differentials are also evident, through asymmetries in expertise and social status and are discussed in section 6.6.6.

6.5 Organisation level inputs

Influences on governance engagement operating at the level of the organisation, in the conceptual framework, include resources and information available. These are discussed in this section, along with the influence of the management hierarchy which emerges as a strong theme in this study.

6.5.1 Resources, size and rurality

The issue of resources available to undertake the work of governing healthcare quality is raised by interviewees, mainly in relation to the staffing of quality units. At C6, one of the small rural cases, the director of quality has one quality manager, with a quality staffer, reporting to them. This contrasts with C8, a similarly sized rural service, where the part-time quality manager is the only dedicated quality staffer. This comparison highlights different decisions made about resourcing quality units between cases of a similar size and revenue base. However, smaller cases generally struggle to address the administrative and compliance requirements of quality within their staffing levels. This

results in little time for development and innovation in quality, as explained by this manager,

> *[larger metropolitan hospitals] have got a business intelligence unit where they get all this data and all the rest of it and we're struggling like, there's just levels. They, they have some scope the bigger organizations to build projects up. We don't have the scope to do that. We are very, very lean and we're very resource poor. I mean all of us. And I would, it's not just the quality mangers but we are all so flat out we don't get done, what we need to do. You're just putting out fires. (IP18, MQ, C4)*

A quality executive in a smaller organisation takes on multiple roles in relation to quality.

> *I do all the strategic risk management for the organisation, the medicolegal stuff, I do all the complaints and patient feedback, community participation I do, I do accreditation, all the incidents sentinel events … I find going down [to statewide quality meeting] because most of the people are from metros or larger regionals than us and they seem to have a great number of people. 'So, my, my person will do that' and I'm thinking, but that's me'. (IP13, DQ, C3)*

In contrast, at C1, one of the larger cases in the study, the executive director responsible for quality has six quality related directors reporting to them.

Limited resources available to quality units in smaller rural services are compounded by the challenge in obtaining skilled staff and board members. C8, with a rapid turnover in quality staff, had experienced trouble recruiting quality managers to their rural location. Similarly, the legislative restrictions on recruiting local clinical providers combined with small rural populations result in two smaller Victorian rural health services, C8 and C4, having low numbers of board members with clinical backgrounds and/or previous governance experience. The challenge of finding suitably qualified board members is felt to have an impact as described by this interviewee, 'dealing with regional boards is very difficult because of the skill set' (IP38, Board member, C8). Two

cases sought external experts to supplement the skill base on the boards as addressed by this interviewee,

> *Something has to be done and if we can't change the board members, we probably need to bring in an external expert. I think that's probably the only way we will get considered challenging of the data or the questioning and that sort of stuff. Bit like an audit or risk committee with some external people on it. (IP27, DQ, C6)*

The information available at the organisation level, as an input influence on engagement, was covered in detail in Chapter 5, when discussing taskwork. As outlined, cases vary widely in the format and content of healthcare quality information provided to inform governance oversight (see Chapter 5, section 5.2). Greater management engagement in processes of preparing data promote greater board member understanding of healthcare quality issues and actions undertaken. The staff and skills available within quality units influence the comprehensiveness and standards of reports produced. For example, at C1, the quality director ensures reports to the quality committee are of a uniform structure and of a sufficient standard to meet the needs of board members. In contrast, at C8, the part-time quality manager has less time to produce reports and is not involved in structuring or vetting reports. This results in fewer reports overall and those that are seen at a corporate governance level are derived from multiple sources and vary in format, purpose and level of detail.

In summary, the resources of the quality unit and information available at the governance level are confirmed to be important factors influencing engagement. Discretionary allocation of resources to quality units, by the executive, is seen to contribute to variable management engagement at some cases. Organisational size and rurality are found to be additional key influences contributing to resources available in quality units. Rurality is also found to be a key influence on the skill set available at the board table.

6.5.2 Management hierarchy

The structure of the executive team and the position of the most senior staff member with designated responsibility for coordinating healthcare quality tasks varies between

cases. Table 26 outlines the hierarchy of quality positions in cases, along with the CEO background.

	C1	C2N	C3	C4	C5	C6	C7N	C8
Director of Quality position	✓	✓	✓			✓	✓	
Manager of Quality position				✓	✓			✓
CEO Clinical Background	✓		✓			✓	✓	

Table 26: Status of quality and CEO characteristics

The striking finding from Table 26 is that where the most senior position for quality is a manager, rather than a director who is part of the senior executive, the CEOs are all from a non-clinical background. If C2N and C7N are removed, where the requirement for an executive quality position is embedded in NSW legislation, the consistent link between CEO background and quality hierarchy is seen.

Executive quality positions are valuable in engaging on an equal footing with other executives and being 'involved in all of the decision making that goes on' (DQ, IP13, C3). Executive quality positions promote consideration of healthcare quality issues at executive level. As explained by a CEO,

> *The importance of that elevation of director of [quality] as being a central role of the executive, with no doors closed to her, her ability to roam freely and get involved in anything, everything. And so really it was, I think to me a critical thing…your executive structure should represent really what it is that you're there to do. (IP11, CEO, C3)*

At C1, the senior quality position is an executive position with the director of quality physically located near other executives. At C8, a non-executive quality manager attends executive meetings and finds this helpful in understanding broader issues,' I certainly heard about it and learned about it through my, through sitting at that level' (IP36, MQ, C8). However, their ability to influence executive discussion is challenging and they feel their role is to say 'this is what needs to happen and what needs to roll out. But you know it wasn't often taken on board' (IP36, MQ, C8). The lack of influence

of the quality manager is evident in their rare attendance at BQC meetings despite being a formal member of the BQC.

> *I asked should I come and I was, the response was 'well the previous quality manager didn't come'. So, there was never, I never got an expectation and it is probably something I struggled with as well is that I never felt like the expectations were very clear. (IP36, MQ, C8)*

The quality manager, who had been in the position for nine months, had never met the visiting Director of Medical Services. The CEO saw the quality manager role as 'more a coordination role rather than actual managing and doing role' (IP35, CEO, C8) and envisaged the manager coordinating delegated departmental responsibilities for compliance with quality standards. At the same time, the CEO recognises the challenges associated with a lack of influence of the manager level position.

> *The quality manager is trying to get people to do things, but they don't have any direct authority. They're always going to be reliant on the director and the department head to get the work done and ensure things, the wheels turning. And I think that's the frustration of being a quality manager. You don't have any real authority and [that's] why there is a turnover in that role. (IP35, CEO, C8)*

At C5, the non-executive quality manager experiences a similar lack of influence and power.

> *People at my level get burnt out really quickly. You're just constantly struggling and arguing. You get to a point you just go, I'm sick of fighting the fight. Because I've got no sort of organisational authority to say look you need to listen to me this is actually important. You need to have me engaged in decisions around ABC at that level. (IP22, MQ, C5)*

At C4, a discussion regarding the inability of quality managers to attend the BQC due to scheduling demonstrates their lack of influence.

> *[The board chair] said well the relevant exec will just have to be up to speed on what all these issues are and then I said well that's ironic that the, the quality committee, the peak quality committee for the hospital doesn't want to speak to, as close as possible, to the coalface and [would] want my word on what was going on rather than the quality manager. (IP17, DMS, C4)*

The lack of influence of non-executive quality staff is compounded at C5 and C4 by their physical location. At C5 and C4, quality managers are separated from the executive, in the former case at a point remote in the building. Physical location of staff is seen to be indicative of the power and status of staff.

> *It sends a very important message... to the, the people in the team, but people outside of your organisation or even like outside the district... So, that's sort of the way that it then makes you feel like you don't really matter. Just tucked away in a corner here. (IP33, DoN, C7N).*

At C3, the placement of offices is carefully considered, 'having your clinical executive clearly in a key position in, in terms of the organisational tree but also clearly in prime real estate' (IP12, DMS, C3). The CEO explains,

> *That's all set up to be like that, so that [director of quality] can stand up and talk to, talk to the director of nursing and the director of medical services and have, work really closely together. And I can come in and talk to the three of them, and I'll stand back a bit and say this is a panel question. You know, but all that stage management, you've got to set up. I'm big into the stage management. So how the personalities link together, how office are positioned, you know all of that. (IP11, CEO, C3)*

The lack of influence felt by management level quality staff is also expressed through their access to the CEO. The quality manager, at C5, who has been in the organisation for over 15 years has never been asked by successive CEOs her 'opinion on what I actually think we should be doing' (IP22, MQ, C5). The hierarchy of quality staff is also seen to impact access to information, not only internally, but externally. In Victoria a

‘[meeting] was set up for the directors of clinical governance network and we don't go because we don't have a director [of quality] (IP18, MQ, C4).

The hierarchy of the senior quality position is a key influence, on corporate governance level engagement with healthcare quality, emerging from the data analysis. This is seen through their access to and ability to influence other executives to keep a focus on quality healthcare and in supporting the implementation of healthcare quality taskwork. This finding highlights that executive composition is an important influence to consider alongside the traditional focus on board member composition.

6.6 External influences

Factors external to the organisation shaping governance engagement in healthcare quality are outlined in this section. The conceptual framework identifies legislation, regulation, accreditation, service agreements and sociocultural factors as potential influences on governance. While the influence of these factors is apparent, the use of evidence also emerges as a key influencing factor from the data analysis.

6.6.1 Evidence and organisational focus

Evidence from reviews of high profile healthcare failures, both locally and internationally, act at the organisational level to increase the governance focus on healthcare quality. The impact is described as, ‘suddenly you know all the minds were focussed after Djerriwarrh [preventable neonatal deaths at Bacchus Marsh hospital] (IP21, Board chair, C4) and ‘a lightning rod like that [preventable death through administration of incorrect gas in NSW hospital] makes everyone just sit back and go oh shit’ (IP6, CEO, C2N). Reviews bring the reality of patient harm to the forefront of the minds of executives, as described ‘I have these visions of Mid-Staffordshire with patients lying there you know totally naked and faeces and all that sort of stuff’ (IP2, DMS, C1).

Board members welcome reviews of high profile failures for the recommendations and guidance on governing healthcare quality. One interviewee explains, ‘I must say I read everything I can get my hands on. I read the Duckett report [in response to Bacchus Marsh hospital] with huge amounts of interest’ (IP10, BQC chair, C2N). Reviews of high profile failures are one of the few sources of directive practical guidance on healthcare

governance available. For example, reviews clarify board responsibilities and tasks, and the information required to be reviewed at a governance level. As an interviewee remarks 'there's a fair bit that I saw in the [review of Bacchus Marsh hospital] around the roles and responsibility of board…That's going to have a pretty big influence on the part of how we go about doing things. (IP22, MQ, C5).

Reviews prompt some cases to proactively reflect on their own quality systems to determine if they have potential issues or 'a Mid Staffordshire on my hands' (IP6, CEO, C2N). At C1, the board and executive had a discussion at a 'board planning day [regarding] could Mid Staff [ordshire] happen' (IP5, Board member, C1). Similarly, at C3, a review prompted governance discussion and reflection, as an executive explains

> *And one of the things we spent a good couple of hours on was this document [review of Bacchus Marsh hospital]. So, that was really running through for the board what were the key themes? … What the challenges are, what the risks are, what the opportunities are for us. (IP13, DQ, C3)*

Governance evidence results in changes to the type of information requested at the board,

> *Djerriwarrh changed that and I can remember being in a meeting and (former Board chair) had shown no interest in clinical governance. And then all of a sudden you know there have been things he'd say explicitly that didn't need to go that meeting, he didn't want to know about. And then all of a sudden post Djerriwarrh 'why aren't we hearing about this'. (IP19, MQ, C4)*

This also leads to creating additional governance reports at C1.

> *It [development of culture report] was out of the events that occurred in the NHS, the Mid Staffs. How do we know there's not going to occur here? … Same thing with Djerriwarrh …What do we need to work through to make sure that we're not in that position? What are the*

learnings out of that how and how can we focus more or, or understand where we are and therefore what are we doing about it? (IP1, CEO, C1)

At C8, the organisational response to evidence from high profile failures is instigated reactively through changing departmental requirements, rather than internal initiatives. Following the Duckett review [in response to Bacchus Marsh hospital], a letter from the health minister, required all LHNs to have BQCs with a board chair. This saw C8 restructure their operational quality committee, chaired by the director of medical service and referred to as the 'DMS meeting' (IP36, MQ, C8), into a BQC with a board member as BQC chair. Similarly, changes to departmental reporting requirements, expressed in the organisation's service agreement, prompts reactive changes to internal reporting as explained by the CEO, 'following Djerriwarrh, clearly obstetric indicators began to be reported' (IP35, CEO, C8).

In summary, evidence from reviews of hospital quality failures is a key influence on engagement in processes of governing healthcare quality either acting directly on cases or indirectly through departmental changes to reporting or structural requirements.

6.6.2 Evidence and government support

Evidence generated by state-wide quality organisations in the form of evidence-based quality initiatives and comparative data, providing objective evidence of a hospital's performance, is also highly valued by interviewees in 'advis[ing] us and provid[ing] support' (IP31, IP31, CEO, C7NN). The provision of data identifying areas of concern is helpful at a governance level, as a CEO states, 'you get caught up in the day to day, you're still trying to be strategic but there's some things you just miss. So, those other agencies, a lot of things we pick up ourselves, and then you go oh shit we didn't know that one' (IP6, CEO, C2N). The respondent goes on to explain,

How do we know we're not going to have a Bacchus Marsh, like Victoria, in maternity? How do we know that? Now the issue about maternity in this state was that because of the CEC [state body] any stillborn babies like that have to get reported to the CEC…We had six stillborn births in say six months. So, it was statistically aberrant. We sort of saw them and went eeerrh bugger. They came back and said to us look we'd like to work with you to do a review. (IP6, CEO, C2N)

Departmental data analysis providing comparative healthcare quality performance information at a state-wide level, assists organisations to 'actually know what's going on' (IP11, CEO, C3) but is felt to be missing in Victoria. An interviewee remarks 'a lot of information and data goes in [to department] but doesn't come back out (IP35, CEO, C8). Another Victorian manager explains,

> *The department has a lot of data and I think they have a limited amount of information and from that they generate a small amount of intelligence. (IP12, DMS, C3)*

The existence of state-wide supports to organisations in governing healthcare quality varies between the two states. In NSW in 2008, the Garling inquiry investigating several serious hospital incidents, made a range of recommendations that included establishing or expanding the scope of existing organisations to become the 'four pillars' (Skinner, Braithwaite, Frankum, Kerridge, & Goulston, 2009). These statutory corporations are responsible for supporting health services in the areas of training, evidence, quality and safety systems and information. At the time of the interviews, Victoria was in the process of developing similar state-wide structures to support quality healthcare in response to a 2016 review of hospital quality and safety (Duckett, 2016). The Victorian Quality Council (VQC), which 'really drove quality and safety within the state' (IP18, MQ, C4), had previously been disbanded and there was perceived to be a current vacuum in state-wide quality support. An interviewee describes this vacuum,

> *When I came to Victoria and there was nothing and I'm saying where are all the things [organisations like NSW Clinical Excellence Commission] … I couldn't believe it I kept thinking, you know, almost looking behind a bookcase it must be here somewhere. There's was just nothing. I couldn't believe it. (IP11, CEO, C3)*

Victorian interviewees want 'standardisation of [quality initiatives] in key areas across the whole of the state that is driven by well-informed evidence base with really good people leading it' (IP11, CEO, C3). It is hoped that this will result in 'stronger quality outcome[s] but you also get an efficiency outcome' (IP16, CEO, C4). Larger Victorian health services, while clearly better resourced in terms of staffing, also feel the lack of external guidance at the state level, as explained.

> *What we miss actually is the investment in the systems here. So, we could have state wide systems and get some economies of scale out of it rather than us trying to invent it and [other hospitals] doing their own. (IP3, DQ, C1)*

Interviewees acknowledge the role of evidence and recommendations from reviews in providing leverage for departmental change in 'ramp[ing] things up' (IP18, MQ, C4). The department is seen to be 'much more active now, since Djerriwarrh' (IP2, DMS, C1). An interviewee explains the impact,

> *It's been a real, real void. And in actual fact post Djerriwarrh if you talk to a lot of people who've been around for a while. They'll tell you we needed Djerriwarrh, as much as no one wanted it to happen. But the department needed that wake up call. (IP18, MQ, C4)*

Without 'independent and autonomous organisations' (IP6, CEO, C2N), as in NSW, the Victorian health department's focus on quality and safety is described as 'wax[ing] and wan[ing]' (IP18, MQ, C4). The waning of Victorian government investment in state-wide quality support is seen to be linked to a move away from centralist control and an increasing focus on devolution of responsibility through local devolved board governance.

> *Different people got involved and the bureaucracy changed and they very much took a hands off role. Devolved governance, it's the Board's responsibility…If [department] had taken those things seriously they might have averted a Djerriwarrh. I can't be sure about that. But certainly there would have been, there was room there for [department] to be more active. (IP17, DMS, C4)*

Both Victorian and NSW interviewees see the advantages of devolved governance in providing boards and executive with 'local autonomy' (IP26, CEO, C6) to make major operational and strategic decisions and to 'hire and fire' (IP6, CEO, C2N). However devolved governance without centralised support is seen as problematic, especially in Victoria with numerous small health services with limited resources for quality, as explained,

> *Devolved governance it's a problem. And I actually think there should be more oversight from the department level because 87 health services all working in isolation in their own silo, developing their own skills, is not really the way to go. (IP38, Board member, C8)*

The lack of Victorian state support of skill development, provision of comparative information, and evidence on effective interventions is seen as hindering effectiveness and limiting the engagement of managers, executive and board members in quality.

In summary, state support is a key factor in promoting engagement in a devolved governance model of healthcare through the provision of data and evidence to cases. Recommendations arising from reviews of high profile failures in healthcare are a major factor in increased government investment in state-wide quality organisations to support hospitals. State-wide quality supports are essential in a system of devolved board governance, especially where organisational size and rurality are barriers to adequately resourcing comprehensive engagement in healthcare governance processes.

6.6.3 Influence of service agreements

State departments exert an influence on governance reporting practices through service agreements. A focus on departmental performance measures, as outlined in service agreements, found in board reporting on quality was discussed in Chapter 5. This focus is at times perceived to be ill judged for two reasons. Firstly, the departmental indicators are not necessarily seen as 'measur[ing] what actually matters' (IP22, MQ, C5). Therefore, cases with a compliance focus on board reporting do not necessarily present a balanced view across the dimension of quality at the organisation. State performance indicators have a greater focus on access, incident and infection data that are readily available to collect and compare across organisations but do not necessarily reflect the risk profile or key priorities of the organisation. Serious incident and infection measures in performance reports often represent relatively infrequent events (Duckett et al., 2018) and are less sensitive indicators of healthcare quality.

The need for organisations to think about the relevance of performance measures used at a governance level to inform the evaluation of healthcare quality is explained by an interviewee.

> *Statement of priorities [departmental performance measures] they're the operational things that we have to sign up to all day every day. They [board] have to be above that and they have to determine which of those SOP's [measures] they absolutely have to monitor all the time every time'. (IP23, DoN, C5).*

Secondly, the interpretation of departmental performance indicators is challenged by several executives, as described in this quote,

> *You know there's so much reactive stuff that comes from the department at quarterly meetings, you know, your performance is deteriorating in you know factor X, but when you look at it and go through the data it's not statistically significant it's just common cause variation. (IP22, MQ, C5)*

At C4, a few serious incidents within a small patient population resulted in a relatively high percentage of events, which compared unfavourably on departmental benchmarking. A manager comments that the department 'don't understand confidence intervals and small samples very well' (IP17, DMS, C4).

State departments are also perceived to influence strategic quality priorities through requirements to address departmental priorities, which is felt by some to leave little room for locally generated strategic initiatives (as described in Chapter 5, section 5.3), as explained,

> *I think more and more the state is the driver in the sense that they actually put out what they expect. (IP2, DMS, CS1),*

However, departments are not the only influence, 'you've got lots of masters…a lot of stakeholders. I suppose from the patient, who tends to get forgotten occasionally, the community, you've got the department, you've got the region, you've got primary care network' (IP15, Board member, C3). Numerous competing priorities arising from various external stakeholders make it difficult for boards to prioritise strategies, as explained by this board member,

> *[It's] challenging to get my head around some of the um. I, I don't know if the word would be, reporting standards, national standards, there's multiple documents, and figure out which is which is the one that's actually the one that's guiding this. So, you've got your statement of priorities which we just signed with the minister'. (IP25, Board member, C5).*

In summary, external organisations such as state departments influence internal reporting on healthcare quality and identification of priorities for quality, but this is not always seen to be guiding governance processes in the direction needed.

6.6.4 Legislation

Legislation has a fundamental influence on governance engagement through provisions in state health services acts regarding board composition, appointment and remuneration. As Table 21 demonstrates, the proportion of board members with clinical backgrounds is greater in NSW cases (C2N, C7N) where numbers are boosted by requirements for local clinician board appointees. Victorian health services, have lower numbers of clinical background board members reflecting the legislative restriction on recruiting clinicians employed by the health service. This results in less clinical background board members in Victoria. This is particularly noticeable in smaller Victorian rural health services (C8 and C4) where it is 'difficult to get the right skills mix just from local people' (IP38, Board member, C8).

Legislation prevents remuneration of board members at the four smaller Victorian health services. A board chair estimates he spends 'probably eight hours a week' (IP15, Board chair, C3) on his role. Being non-remunerated is seen as an impediment to attracting board members as explained, 'want a skills-based board [for an over 100 million] dollar organisation and you don't get paid!' (IP15, Board chair, C3) or as another board member remarks 'if you pay them peanuts you'll only get monkeys' (IP14, Board member, C3). This contrasts with larger cases, such as C1, where all board members receive some remuneration for their time on the board, and the organisation can attract more experienced board members.

Victorian legislation requires ministerial approval of a departmentally coordinated board appointment process. The process is seen to be influenced by politics 'you don't

vote Labor so [the Labor minister] doesn't reappoint you (IP24, BQC chair, C5). Interviewees felt the 'political process' (IP23, DoN, C5) of appointment limited their ability to address skills gaps. In response to this, C5 and C6 had or were seeking to appoint *ex officio* BQC members to augment the skills base in relation to healthcare quality.

Legislative changes in NSW saw health boards re-established in 2011. This change saw a shift in responsibility for healthcare governance from advisory councils, with no direct responsibility for quality, to one where the 'board has a primary responsibility quality and safety. So, it's quite different' (IP31, CEO, C7N). Only at the end of the data collection period an amendment to the NSW legislation transferred the ability to appoint CEOs from the secretary of the department to the board (Government Sector Employment Legislation Amendment Act 2016 No 2 [NSW], Schedule 2, Amendment of Health Services Act 1997 No 154, section 28)

The impact of prior governance arrangements is noticeable in the NSW cases. The legacy of a more centralised system, with responsibility for quality a direct accountability of the CEO to the ministry, is seen in the way management engages boards in oversight of healthcare quality. NSW cases have the lowest proportion of board members at BQC meetings. The C2N and C7N BQCs are observed to have a strong focus on operational issues at a network level. BQC papers indicate that the two NSW BQCs act as a central point for sharing operational level information arising from or relevant to separate sites and program areas. This contrasts with most Victorian cases with operational level quality committees in addition to the BQC. The existence of this two-tiered quality governance structure in Victorian cases frees the BQC to be, potentially, a higher level of quality oversight than that occurring at the operational committee.

The NSW legacy of management responsibility for healthcare quality is particularly noticeable at C7N, where the CEO recently became chair of the BQC, despite it being a board committee normally chaired by a board member. The BQC meeting is observed to be focussed on operational matters relevant to clinical managers, and board members have minimal engagement in discussion at the committee. Government directives and model by-laws encourage the development of a two-tiered approach to

quality governance, with the establishment of both more operational hospital clinical councils and separate board healthcare quality committees (NSW Ministry of Health, 2012). However, only the former is established at both the NSW cases, meaning this committee acts as the central point for discussion of operational issues occurring across the network.

In summary, legislation is a key influence on governance engagement. Legislation has a fundamental influence on the ability to attract and recruit suitably experienced board members. The influence of previous legislative arrangements is evident in the approach to implementation of new local governance structures for healthcare quality in NSW.

6.6.5 Accreditation

All cases undergo accreditation through national healthcare standards. The influence of accreditation in driving governance focus and organisational activity in relation to healthcare quality is acknowledged by most interviewees. Recently introduced national standards are seen as 'a game changer' (IP3, DQ, C1) and helpful in identifying 'what are the things we should be concerned with' (IP35, CEO, C8). However, in some cases, accreditation standards are seen to shift the governance focus to external priorities for quality, which often, but not always, align with organisational needs. A focus of reporting on national standards is seen at the C8 BQC where the committee structure had been changed 'to make it both more aligned with these standards' (IP39, Board member, C8). The agenda reflects this focus with 'every standard, something in that standard, is covered in that quality meeting' (IP37, DMS, C8).

Some interviewees feel accreditation fosters a 'compliance focus' (IP36, MQ, C8) on healthcare quality governance. This is highlighted by a board member at C8.

> *IP39: It's [accreditation] critical for the organisation. Critical for reputation. It's critical for funding. It's critical for quality and safety because if we can't achieve accreditation, we can't be delivering, we can't be sure we're delivering a safe quality service if we can't get accredited for it.*
>
> *R: So, does that give you assurance, when you have accreditation, that you've got a safe and quality service?*

IP39: Yes.

Executives at other higher engaged cases counter this view. 'They're [the national standards] simply about the base, just about the base and nothing more' (IP23, DoN, C5). At another higher engagement case the view is that 'you should really aim to shoot above any standards-based structure' (IP9, Board member, C2N). This alternative view acknowledges the importance of the national standards in establishing baseline or minimum acceptable standards but does not see attaining the national standards as an end point for healthcare quality. A few interviewees are doubtful about the impact of accreditation in terms of improving the quality of care for patients. This is reflected in comments such as 'it's appearing to meet what the accreditors are looking for without actually doing the right thing for the sake of doing the right thing' (IP10, BQC chair, C2N) and accreditation activities 'don't necessarily highlight where there might be problems' (IP33, DoN, C7N).

In summary, accreditation is seen to shape the governance focus and activities in relation to healthcare quality at some cases. The influence of accreditation in determining the focus on quality, at a governance level, is less evident in more highly engaged cases.

6.6.6 Sociocultural

Sociocultural influences on governance engagement in the form of gender or social status, while not directly explored through interview questions, are evident. At the corporate governance level, the dominance and status of medical professionals at the board table are mentioned by a few interviewees, as explained, 'our system is still very medically driven. So, the opinion of the senior medical clinicians is that the one that is often sought' (IP33, DoN, C7).

A theme raised by several female interviewees is the influence of gender on governance. At C4, where a female board chair replaced a male board chair, the following comments are made,

> *I think you know there's perhaps a bit more of a willingness to ask a silly question. Or go … Why is it different? …Maybe it makes me feel*

more comfortable having more women on the board. (IP21, Board female board chair, C4)

All of a sudden now we have got more females on the board. We've had a change of leadership [female chair] and there's certainly been a change of focus. (IP19, MQ, CS6)

The influence of gender is apparent in the position of the most senior quality staffer at cases. At all but one Victorian case, this position is held by a female and half the cases have non-executive quality directors (NSW cases excluded as executive quality positions are mandated). This contrasts with the senior finance position which, in all but one Victorian case, is a male and all are executive positions. A few CEOs argued that non-executive quality positions reflect financial constraints on the number of executive appointments. Quality managers felt this positioning reflects a lack of acknowledgement of the importance of healthcare quality at the corporate governance level (see Chapter 6, section 6.5.2). A third possible explanation is gender inequality.

Sociocultural influences were not investigated in the depth required to make any conclusive statements about their influence. However, the acknowledgement of these factors by interviewees indicates their likely influence in shaping attitudes to and practices of governance. Sociocultural factors require future focussed examination to confirm their influence on engagement at the governance level. For this reason, sociocultural influences remain a theoretical construct in the framework for which this study is not able to confirm.

6.7 Chapter 6 Summary

This chapter has outlined the influences of various inputs operating at the individual, board, organisational and external level on governance engagement in healthcare quality. Through comparing cases with different levels of engagement, the influence of constructs, presented in the theoretical framework, were tested and new constructs were identified through the data analysis.

This chapter confirms that all constructs presented in the framework under the input category are relevant, excepting two constructs. Power when defined in terms of board decision-making autonomy is not relevant in the governance setting. Limited evidence

and exploration of sociocultural influences on governance engagement, means that while these factors are likely to be operating on governance engagement, their influence has not been confirmed in this study.

Emerging from the analysis are influential constructs, management hierarchy and evidence, not previously identified in the literature and not included in the original conceptual framework. Executive quality staff positions are found to be important in driving the healthcare quality agenda at both the executive and board level. Evidence in the form of reviews of high profile healthcare failures are found to be influential both via an indirect influence on activity at the state government level and more directly on organisational healthcare quality governance activity. Geography and size have also been added as organisational inputs influencing board and management composition and skills.

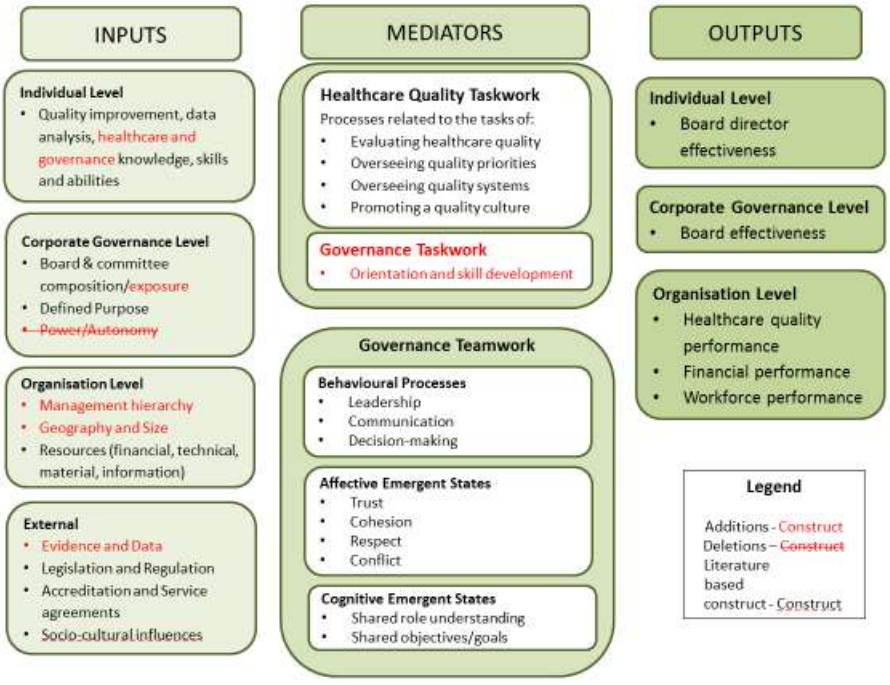

Figure 8: Changes made to conceptual framework from Chapter 6

While confirming most input constructs in the framework influence governance engagement, this chapter also provides a deeper understanding of constructs such as KSAs and governance composition. The analysis moves beyond the traditional focus on

clinical and data KSAs to identify the value of board members with governance experience and a broader understanding of healthcare. Similarly, the examination of governance composition reveals both the proportion of board members to managers at the BQC and board member BQC exposure, influence engagement through providing greater opportunity to participate in and undertake the tasks of governance. This highlights the BQC as an important forum for understanding influences on healthcare quality engagement.

The analysis of KSAs also makes apparent important governance processes of board orientation and skill development for both managers and boards. These processes had not originally been considered in the healthcare quality taskwork category in the conceptual framework presented in Chapter 5 and are added to a governance taskwork category in Figure 8.

This chapter has identified multiple inputs that shape governance structures and the activity of senior management and board members in governing healthcare quality. Chapter 7 continues the analysis of influences on engagement through examining mediating constructs in the teamwork category of the conceptual framework.

Chapter 7 Teamwork Mediators

7.1 Introduction

This chapter continues the exploration of influences on governance engagement that began in the previous chapter. Factors related to the board and management working relationship found to influence engagement with healthcare quality governance tasks are described. This relationship is examined through a focus on mediating constructs in the teamwork category as outlined in the conceptual framework developed in Chapter 3 (see Figure 9).

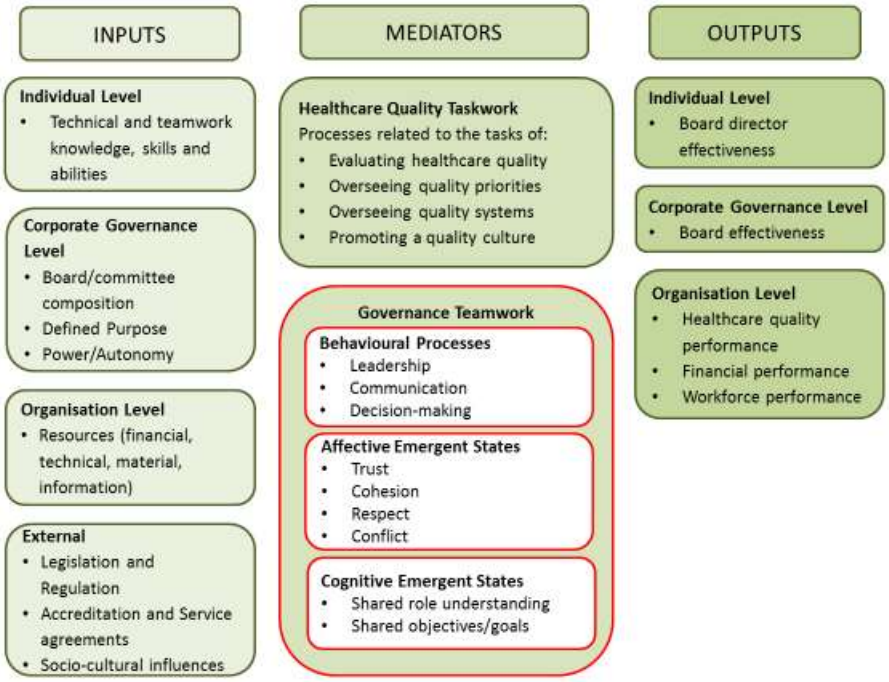

Figure 9: Teamwork mediators in the conceptual framework

Constructs mediating governance engagement in healthcare quality are described within the categories of behavioural processes, affective and cognitive emergent states. Constructs, within these categories, are presented as discrete entities for the purpose of presenting findings clearly. However, the interconnectedness of many mediating constructs is evident throughout the analysis. The interaction of constructs influencing engagement are explored further in Chapter 8. This chapter has a focus on presenting evidence as to the relevance of individual teamwork constructs, from the framework, in

influencing governance engagement. Constructs emerging from the analysis of the data are also described.

Evidence of teamwork constructs influencing governance engagement is derived mainly from interviews and BQC meeting observations. This chapter highlights the influence of mediators through comparing C1 and C8, the highest and lowest engaged cases. However, the abstract nature of the teamwork constructs makes it challenging to always provide clear evidence of variation in construct influence between cases of different engagement scores. To address this, evidence from multiple cases supporting the influence of a construct on engagement is presented, when required.

The exploration of teamwork constructs commences by addressing key behavioural processes influencing engagement. Communication and leadership are found to be central constructs in effective governance. While these have been identified in previous literature, this chapter adds to the literature by expanding on how these constructs act to influence governance engagement. Open communication, the provision of clear logical narratives in reporting and effective questioning and challenge from board members are important aspects of communication found in this study to support governance engagement. An aligned leadership focus on healthcare excellence along with a quality improvement culture and effective meeting leadership are also important influences on engagement. The exploration of behavioural processes highlights an emergent construct, reflexivity, which promotes reflection and review of governance issues and refinement of practices.

Affective emergent state constructs, trust and respect, are found to influence engagement via their impact on communication. Shared understanding of healthcare governance tasks, a cognitive emergent state, is found to be lacking across most cases. The chapter concludes by finding all constructs in the teamwork category of the conceptual framework are relevant in the governance context, with the addition of the reflexivity construct.

7.2 Communication

Communication is found to be a critical influence on governance engagement in healthcare quality in this study. Characteristics of effective communication that are

influential, and are outlined in this section, include clear language, open communication, time for discussion, effective questioning, challenge and formal BQC communication. The approach to verbal and written communication is addressed in this chapter, rather than the content of information provision which was discussed in Chapter 5.

7.2.1 Clear narrative

The need for 'plain English' (IP22, MQ, C5) in presenting complex healthcare quality information is consistently raised by board members, particularly those with non-clinical backgrounds. They encounter a 'vastly different language' which compounds an 'information asymmetry' (IP5, Board member, C1) and is a barrier to understanding. A respondent explains,

> *I think it's really quite hard if you don't have that [clinical] background to not be overwhelmed by. It's a whole different linguistic terrain, as you know. And I know even myself, I think I'm reasonable because I'm from allied health, but there are still things I go 'oh what is it'. (IP9, Board member, C2N)*

Removed from continuous exposure to issues through day-to-day operations, board members need to be provided with a coherent, logical narrative of events. Management have a key role in ensuring effective communication of complex information, as described, 'representatives on the committees such as, you know [Director of Quality], they're there to make the connections, they are there to tell the story (IP4, BQC chair, C1). The following interviewee further explains,

> *It's incumbent on us as an executive to be clear and focussed and good at explaining …why we are doing things this way and not that way. What our priorities are. (IP8, Manager, C2N)*

Developing a clear narrative to foster board understanding requires a 'greater rigour in language and explanation' (IP11, CEO, C3) from management than needed at an operational level. This often requires reformatting management reports as described by a manager, 'all the data that we use at [operational committee]. I then rewrite into plain

language so that people can understand what we're actually talking about' (IP22, MQ, C5). This clear logical narrative also enhances the understanding of non-clinical executives at the board table. A non-clinical CEO explains the language barrier that exists for some staff, 'he's [DMS] using all the acronyms. And I'm thinking what. I'm not going to question what they are' (IP35, CEO, C8).

Deliberate efforts are made at C1 to refine and tailor the language and approach to board reporting. Briefing documents are often developed providing an overview of the report origins and issues identified. An interviewee elaborates,

> *I say that to my staff, you know, sometimes you think we are being overly detailed about things because we revise and we revise and we revise. But the further up it goes, it's different … you have to be really clear. (IP3, DQ, C1)*

This interviewee goes on to give an example of a presentation on an area of clinical risk which focussed on telling a logical narrative.

> *Much of this is sort of stories … So, can you prevent suicide [in the psychiatric service]? What, what do we know about suicide and our ability to influence that, you know. So, we had to get an evidence base and then we had to actually be able, be able to tell the story of the evidence base and then, and then say well this is how we're going in relation to that. (IP3, DQ, C1)*

The C8 document review revealed data that is provided with little background and the BQC meeting observation highlights the delivery of detailed individual patient clinical management information. Information is not tailored to provide a high-level narrative overview of issues appropriate to governance oversight responsibilities. The quality manager feels she is encouraged to write reports addressing operational management.

> *There was a real sense of just being, to prepare for their questions about little things … So, this person fell seven times and we did all this and now they are not falling and that's great. But there wasn't a lot of*

sort of now we're doing all this to stop someone else falling seven times. (IP36, MQ, C8)

The CEO reflects on the effect this is having on the board.

We're our own worst enemy. We take them, bringing board members to a subcommittee meeting, you know, feeding them operational information, so dragging them down into operations but then expecting them to push back up into strategy when they get to the board. So, we need to think about what we're doing in the subcommittees. (IP35, CEO, C8)

Carefully preparing board information to facilitate understanding and ensure an appropriate governance-level focus on strategic and system-level issues is encountered more often in cases with higher engagement scores. The difference in approach to clear, narrative communication is evident between C1 and C8.

7.2.2 Open communication

The extent to which communication is perceived to be open and transparent in enabling board members to have 'a balanced view' (IP4, BQC chair, C1) of healthcare quality is discussed by most interviewees. A commitment to transparency at C1, C3 and C6 is evident in consistent interview responses from both board and executives. At C1, board members see the provision of healthcare quality information to be 'it's warts and all' (IP4, BQC chair, C1) and 'the board is in lock step, we know as much as managers know' (IP5, Board member, C1). This is reflected in the CEO comments about the approach to informing the board about areas for improvement.

There's nothing to hide here. We know we haven't got this right. We want to look like this and it's looking like this. And so therefore this is how we're trying to get there. (IP1, CEO, C1)

This contrasts with C4, where a strained relationship between the former chair and executive impacted on the openness of communication and resulted in gatekeeping of information.

IP18: we never used to filter for what went through. And that's the trouble I've been here too long. I know what's it's been like.

R: So, when did the filtering start?

IP18: well I would have said when [former chair] became [chair] of the board.

R: OK. So, when that relationship deteriorated between?

IP18: Yeah. And it did, all of a sudden, you know [the previous CEO said]. ''No, you can't, that's [information] not going. No, that's not going". (IP18, MQ, C4)

The retirement of the chair saw a return to more open communication, although the process was slow and linked to rebuilding a trusting relationship.

I think we've gone through that process, as I was talking about, where there was no sharing. And now it's this tentative sharing and discussion and whatever. But we haven't gone full bottle on being quite open and transparent, that kind of thing. That's the next level of maturity. And I'm not sure, that's going to take some time to get there. So, look to me it all comes back to trust. (IP16, CEO, C4)

At C7N, an executive hints at other executives limiting information seen by the board.

You can shut down, you can you can put boxes around things and you can say this is the structure I want to have so you can keep it contained. I'm not saying that that's the case but, but you can control the flow of information…When [executive] is not there…often the conversations is much more open and free flowing compared to [when executive present]. (IP33, DoN)

Interestingly at C8, less is said about openness by interviewees. One illuminating communication example relates to a consultant's report on improvements needed to perioperative services, which is actively resisted by some board members. A few board members framed the issue as a problem with the way the consultant had undertaken the review, as retold in the following.

> *'What does this woman know?', 'She's, she's from the [location] Mafia'. I felt at that stage things had broken down. 'This is a gross overreach of this report', 'If this was implemented it would close down half of the operating theatres in country Victoria'. And the problem is? (IP38, Board member, C8)*

Open communication is often considered in terms of whether information presented by management to boards is transparent. This C8 example demonstrates open communication by management with a lack of openness or receptivity to hearing about underperformance by some board members.

Framing information regarding underperformance as a problem with the robustness of the data is also seen at the C8 BQC meeting. A manager frames clinical audit results, indicating incomplete falls assessment screening being undertaken, as a problem with the audit sample size. Framing of a different nature occurs when an executive, after discussing a preventable near patient death due to problems with medication management, said that it would have been 'sad coming in with mild back pain and ending up dead' (IP37, BQC observation notes, C8), conjuring an image of an unfortunate event rather than a preventable event. C8 highlights the importance of both the openness with which information is provided and received in the governance context, both elements of communication addressed in the team literature (Jelphs & Dickinson, 2008).

Open communication of underperformance enables board members to focus on monitoring improvement and ask 'let's find out more about that. And understand what's being done to address that. And let's hear the outcomes of that' (IP9, Board member, C2N). Open and transparent communication, while appearing robust in some cases, could change with governance composition and the nature of board and senior management relationships as seen at C4, with the relationship breakdown leading to gatekeeping. At C8, while management communication of healthcare issues is transparent, it is on occasions framed to provide alternative interpretations than underperformance, and acts to inhibit further board questioning.

7.2.3 Discussion

Adequate time at the BQC, for discussion of information presented in reports, is an important influence on engagement. Within the semi-structured interview, interviewees were asked one closed question with three possible responses. Interviewees were asked to select one or more of three statements that represented BQC communication. The statements are;

- Brief efficient discussion of information presented
- Lively open debate of information presented
- Limited time or opportunities for further discussion

Twenty-seven interviewees provided 47 responses to the question as shown in Figure 10.

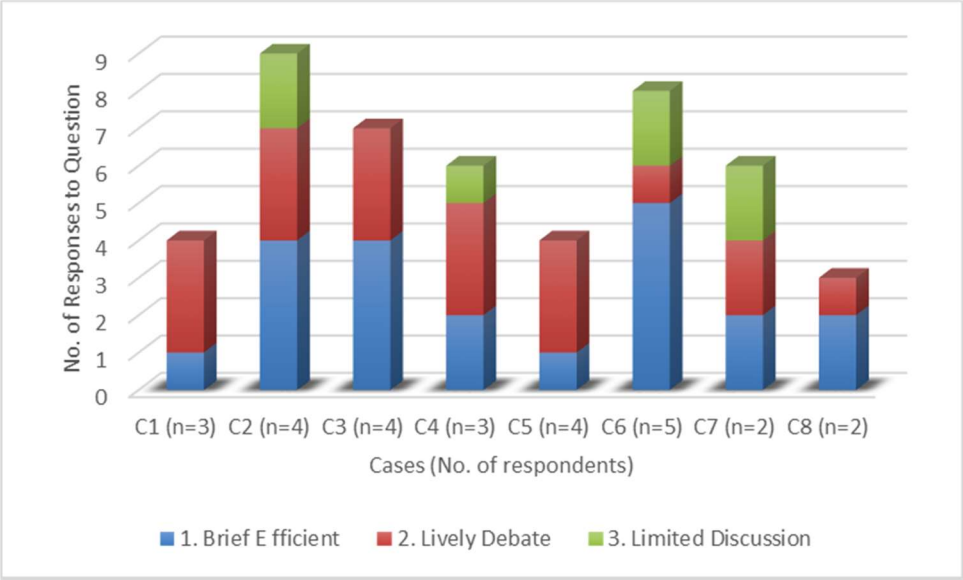

Figure 10: Communication style at BQC

Brief, efficient discussion, lively open debate and limited time or opportunities for further discussion are selected 21, 19 and 7 times respectively. Figure 10 shows that 'lively open debate' is selected less often at the three lower engaged cases. Enabling time for 'some robust discussion' (IP17, DMS, C4) of key issues is seen by both managers and board as integral to effective meetings. An interviewee remarked that 'the culture that I would be looking for is that lively and open debate. And it's a good meeting when you get that' (IP23, DoN, C5). This is reiterated by a CEO.

> *So, I'm a great believer in driving governance, not just through tidy board minutes but actually conversation. And I think that…doesn't happen enough, you know, because not everything can be covered off in a brief. (IP11, CEO, C3)*

The appropriate balance of efficient discussion and lively debate is essential and when the balance is wrong it results in limited time for discussion. The following summary notes of the observation undertaken at the C1 BQC meeting (see Box 1) outlines their approach to creating time for discussion. This summary also illustrates the influence of other key teamwork constructs which are be referred to in later sections.

16 participants were present at the C1 BQC meeting including the CEO, Clinical executive, 2 community representatives, 4 board committee members and a new board member observing the meeting. The chair commenced the meeting seeking board member input on agenda items marked for noting, to determine if board members had questions about these items. The 105-minute meeting was characterised by frequent questions by board members and community representatives. An agenda item on serious clinical incidents was accompanied by a summary document in meeting papers, outlining trends and types of incidents along with a high-level summary of each serious incident and action undertaken. The chair assumed the document had been read and 15 minutes spent on this item largely involved questions by board members and a community representative leading to detailed discussion of data robustness and incident review processes. Discussion resulted in an action for further information about incident review processes to be reported back at the next meeting.

Half the meeting was devoted to in depth presentations of two areas of clinical risk. In a presentation on pressure injury management, a clinical manager clearly outlined background information about the impact of the risk, current management and organisational wide issues identified. The clinical manager described issues as 'our risk is significant' and 'we've exceeded the target in the negative sense, so we have got some work to do'. The presentation lasted for 18 minutes and then 6 minutes were spent addressing board questions.

Throughout the meeting the chair directed opportunities for questioning to board members, paused to allow time for additional questions to be raised, summarised discussion and action arising.

Box 1: C1 summary observation notes BQC meeting

The preparation of comprehensive summary information in committee papers, at C1, allows papers to be either formally noted or assumed read and committee time to be directed to questions. In contrast, the observations of C6, C7 and C8 BQC demonstrate limited time for discussion. These meetings are dominated by the provision of a large volume of information by management. A summary of the meeting observation at C8 is provided to highlight the different approach to communication.

The C8 BQC meeting was attended by 12 people including the CEO, clinical executive (but not the quality manager), Director of medical services (DMS), 2 visiting medical staff and 3 board members and lasted for 50 minutes. Discussion of 3 serious clinical incidents took 26 minutes. Summary information about the incidents was not available to BQC members in meeting papers. Most of the time was spent by the DMS giving detailed information about symptoms, investigations, medication and the sequence of events for each patient incident, often using technical language, for example, in reading out imaging results. A clinical background board member was drawn into discussion, along with other clinical managers, of individual clinical management. Two non-clinical board members remained silent during this agenda item. Systematic issues in clinical assessment, documentation and referral were evident and briefly alluded to by the DMS however, actions or recommendations were not discussed at the meeting nor picked up by the chair. A question regarding a patient's communication with medical staff elicited the response that the patient was saying 'not very much at the end' and drew laughter from the whole group.

A board member's question about a red flag result on a falls assessment screening audit elicited the management response that results from 'six [patients] doesn't really give you anything of statistical significance' and a later comment that the audit staff may have 'misinterpreted auditing questions'. This led to a discussion of possible changes to methodology. A staff member suggested some follow up of methods was needed, the chair agreed it was worth looking at but no definitive action or reporting back was identified.

The meeting involved minimal contribution from one board member. During the meeting the chair introduced new agenda items, asked for questions and occasionally asked questions of management.

Box 2: C8 summary observation notes BQC meeting

Lengthy management presentations at C8 BQC meeting, delving into individual patient management, are costly in terms of lost opportunity to discuss issues and important agenda items requiring greater attention. The need for a considered balance between brief noting of information and more engaged discussion and debate in meetings is evident. This balance is evident at C1 where time spent discussing issues raised in reports is maximised.

7.2.4 Effective questioning

The skill of board members in asking questions is vital to effective discussions and good relationships. One board member describes this skill as 'disagre[ing] without being

disagreeable … Ask questions without being a smart arse' (IP10, BQC chair, C2N)'. Board members find it 'hard to ask questions' (IP14, Board member, C3). It is seen to take time to develop this skill, as this board members explains,

> *[I've] been on [the board] for a while, I feel like I've got enough continuity as well as understanding of where the right questions might need to be asked and in what way. (IP25, Board member C5)*

Board members are often very thoughtful and cautious in their composition of questions as another board member explains,

> *I find it frustrating because you get to the stage where you have got to frame your questions really carefully otherwise it looks like you are trying to catch them out. But, and you are sort of trying to catch them out in a way. (IP10, BQC chair, C2N)*

Board members are 'constantly trying to work out that line between governance and operational' (IP14, Board member, C3). Navigating that divide requires careful composition of questions as outlined,

> *I would like to get in and suggest ways things could be done better. But it's not my role. So, I probably I focus more … around so this is the approach you've adopted. Are there any, are there any alternatives that you decided not to adopt. Which is a fairly clear way of saying I think you could have done it differently without actually saying it in a way that steps over the line. (IP39, Board member, C8)*

Questions can be constructed to reduce the sense of challenge as shown in this excerpt, 'people sometimes frame it and say look I'm sorry I don't understand this' (IP23, DoN, C5). Questions are also composed as a way of communicating concerns to other board members, 'how can I ask the question in the right way to try and reveal the problem to everyone else' (IP10, BQC chair, C2N).

The ability to question is influenced by board members 'having the confidence' (IP5, Board member, C1) to speak to senior executives and clinicians, particularly doctors. A

board member explains the influence of perceived differences in the status of governance participants.

> *If you've been someone who has been a community member and lived in the community for a long time, you might know the community well. And that's, that's important knowledge too. But I really think that makes it very hard to have the confidence based on experience and understanding to interact in a way that contributes to good governance. So, we've had, probably, a couple of people who were just very quiet, who don't say much. And that's what I worry about. Because that, they don't have anything to say or that they don't have the confidence to speak or they are not across it. It's not a criticism of them. It's just my observation wow, how are you travelling? … I think you've got to be able to have that confidence and the assertion to say, even if it is to the CE[O] or to the chair, 'Hang on a minute I want to go back and look at this again I'm not happy with this' or 'I want a more in-depth response on this' or whatever it is. (IP9, Board member, C2N)*

An environment where board members feel their questions are welcome is important in overcoming the perceived information and hierarchy asymmetry between some board members and executives and clinical background staff. A welcoming approach to questions is evident at some cases. Board member orientation at C3 includes advice to 'please ask the question because if you're thinking the question there might be two or three others who are thinking it also. So ask it' (IP14, Board member, C3). An executive director at C5 explains their similar approach.

> *I don't think any question is unwelcome and even if it's, you know, not well put. I think it's our role to understand the question that is being asked and to either take it on notice or reassure the person that we actually do understand that and we understand the reasons for the variances. (IP23, DoN, C5)*

However, managers appreciate a respectful approach to board questions 'without coming out and saying [CEO] I think you've got a problem in X. Using a bit more sophistication in their approach' (IP1, CEO, C1). The interviewee goes on to explain,

> *Can you give me more information on why, why is this happening the way it is? Help me understand this then I can make my I can satisfy myself where this is going on. And that's what that humble inquiry about asking the question rather than oh [CEO] a problem in here. You know why aren't you do something about it. You know it's a very negative tone. Whereas this, it's actually about the improvement and OK, that's not where we wanted to be. (IP1, CEO, C1)*

Questions 'asked in an appropriate way' (IP12, DMS, C3) acknowledge the actions and initiatives of staff.

> *The data is very open and transparent and so blind Freddy can see we've got, you know, there's an issue here. And so, it's more we're pleased to hear that you are doing something about this particular area. And you, you've got a strategy. We'll keep a watching, a watching brief on it to see how that's working. Yeah, that's a subtle inquiry, the subtle focus. (IP1, CEO, C1)*

Effective questioning sometimes relies on effective listening and some board members 'might only ask one question per meeting but just watch [they're] very, very good' (IP25, Board member, C5). Listening is a challenge for some board members who are keen to contribute.

> *Sometimes the challenge literally is about having to just let people do their job and not try and you know we're all, we're all experts in our own mind. So sometimes it is. Hang on. That's actually the expert. Let's stop and listen and then. So sometimes it's just that, that we're all people full of bright ideas and sometimes we just have to, to hold those ideas and let the people the people actually charged with doing the job do it their way. (IP39, Board member, C8)*

Effective questioning is a skill that board members feel varying degrees of confidence in undertaking. Framing questions to acknowledge information provided, management expertise and actions is important in maintaining good relationships at the board.

7.2.5 Challenge

Closely related to effective questioning, is the concept of challenge. The value of board questions in constructively challenging thinking and assumptions is consistently raised by managers from every case despite no interview question directly addressing this. Most managers feel they 'like to be challenged' (IP17, DMS, C4). This means not only that managers like to 'be asked more questions' (IP28, MQ, C6) but that they welcome the board to be 'searching in their questions' (IP2, DMS, C1). While a few executives acknowledge that at times questions 'can be frustrating' (IP11, CEO, C3), the benefits of constructive questioning are seen to outweigh the challenges as described,

> *Sometimes I feel quite uncomfortable, they are putting a bit of pressure on. But that's what their role is and I'd actually much rather them doing that. (IP18, MQ, C4)*

Managers sometime have trouble shifting from an operational to a governance perspective, described by this interviewee as not 'see[ing] the forest for the trees' (IP16, CEO, C4). Constructive challenge lifts managers out of 'what's going on every day' (IP1, CEO, C1) and encourages a broader perspective. Effective board challenge creates an imperative for executives 'to think more about the data that's been presented' (IP28, MQ, C6). This has an influence on future directions and actions taken as this interviewee notes,

> *What I call quite subtle inquiry, that actually [can] have quite a significant impact and shape on the focus and how you actually do your business. (IP1, CEO, C1)*

Effective challenge is seen to hold management to account in a useful way, as one manager explains,

> *They do ask the hard things of us which we appreciate because it keeps us on the ball … But we sometimes don't, we overlook the obvious…because it is so common place here and so they'll often say but why haven't you tried this or have you tried this or you know, I mean, they're not operational but they'll ask a decent question that makes you think, 'um yeah okay, yeah, good point'. (IP13, DQ, C3)*

Many respondents note the broader perspective brought by non-clinical board members is particularly valuable in challenging assumptions and providing a 'check against group think' (IP12, DMS, C3). Constructive challenge is often expressed simply through fundamental questions, 'it's questioning why, it's questioning how' (IP25, Board member, C5) as explained by this manager,

> *So, having people who are coming from a, almost an unformed perspective, if you like. Not uninformed. I would say unformed… can sometimes ask … why the emperor has got no clothes. (IP12, DMS, C3)*

The act of simplifying questions serves two key purposes. In the first instance, the simple questions drive a greater appreciation of the organisation's accountability to the community or a bringing 'back to reality' (IP17, DMS, C4) that executives are not exposed to in their everyday work. As a CEO explains, 'I think dealing with well-informed but nonclinical people in governance actually drives a broader accountability' (IP11, CEO, C3). Secondly, simple questions allow the whole board to develop an understanding of an issue.

> *Sometimes the best questions actually come … from the non-quality people just going 'that doesn't make sense, explain it to me' and when people have to explain they, that educates everybody. (IP15, Board member, C3)*

The observation of the C8 BQC, outlined in Box 2, highlights that questions came predominantly from one board member. At C6 and C7N, also cases with low engagement scores, the lack of questioning from board members at the BQC is apparent both from interviews and observation. At C7N, a manager reports that 'there's no challenging of, do we really know, have we really had a good look at the results of this particular indicator and why' (IP33, C7N). Similarly, at C6,

> *I don't think there is any value in either of those board members being on that committee… they are not engaged they are not asking probing questions. (IP28, MQ, C6)*

Constructive board challenge in the form of questions, sometimes as simple as 'why has this happened' and 'how have things changed' is powerful in promoting a greater

management focus on analysis of issues and action implementation that can sometimes be lost among day to day operational pressures.

7.2.6 Formal communication

Communication involves not only the act of discussing and questioning within meetings, but the formal reporting and accountability between governance structures that is integral to governance. A key function of any board committee is to regularly report and communicate significant issues to the whole board. The approach to addressing this requirement at the BQC vary between cases from the provision of minutes only (e.g. C4, C6, C8) to a verbal chair report (e.g. C1, C2N, C5).

Committee chair reporting is seen by this interviewee to be 'a really important role to make sure the board's really aware of things' (IP25, Board member, C5). The absence of BQC chair reporting at C6 is seen as 'an opportunity that they've lost at the board' (IP27, DQ, C6). A similar view is held at C8.

> *The board receives subcommittee reports, and they just accept them as minutes there's no discussion. In other places I've worked the chair of the Board subcommittee is one of the board members and they will provide a very brief verbal report saying these are the key issues that we discussed. You'll find them in the minutes. So, we talked about X Y and Z. Are there any question, do you want to flesh them out? But that doesn't happen, it's just these are items for noting, so we note them and let's move on. Which I think is a lost opportunity really both for board development and for broader thinking about what else can we be doing. (IP35, CEO, C8)*

Limitations of minutes and second-hand reporting, along with an awareness of the need for a greater board focus on quality led C3 and C5 to develop strategies to increase the number of board members at the BQC. While this is not a strategy pursued by many cases it does highlight the influence of verbal communication in fostering understanding and highlighting quality issues. Verbal communication of BQC issues by the BQC chair to the board is encountered more often in higher engaged cases.

In summary, this section has outlined how communication acts to influence governance engagement in tasks of healthcare quality. Given tasks of governance are cognitive in nature and centre around the exchange and analysis of information, the importance of communication is not surprising. This examination of communication highlights the need for well-presented, logical, transparent information that enables time for robust discussion and challenge at the governance level.

7.3 Leadership

Leadership, the other key teamwork construct influencing governance engagement, is examined in this section. The influence of a CEO, board and quality chair, in mediating governance engagement in healthcare quality are considered through exploring the focus of leaders, the alignment of leadership focus and through effective leadership of meetings.

7.3.1 Leadership focus

A key governance responsibility is ensuring a strong focus on healthcare quality, along with the historical preoccupation with finance. Two main leadership orientations emerge from interviews, leaders that focus more on finance and those that focus on healthcare quality and see that financial efficiency will follow. As explained by this CEO, 'if you stick to the patient first, everything else will flow from it. So that's what you try to focus, that patient first. Everything else flows' (IP6, CEO, C2N).

Three of the five lower engaged cases are perceived to have a stronger focus on finance than quality (C4, C5 and C8). This focus on finance relates to recent financial pressures at all three cases, as explained by these two staff.

> *When I arrived, there were significant financial difficulties as well. So, the focus for the first 18 months was purely let's get back on track financially. (IP35, CEO, C8)*

> *A lot of the [quality] metrics coming in are all looking okay here. So, if you're a board member and you've got you know a massive financial problem. Where are you going to focus? (IP22, MQ, C5)*

The challenge for leaders is to not lose sight of quality considerations as explained, 'maintain the focus on quality and safety. But still got to put a bit of urgency around rectifying where we can the financials' (IP16, CEO, C4).

Interviewees identify the need to integrate quality considerations broadly across all corporate areas and understand 'how the dollars are driven by some of the … quality outcomes' (IP4, BQC chair, CS1). This interviewee explains further,

> *Quality and safety for patients is through every aspect of what we do, whether you're in finance or whether you're in procurement, you know how we procure our equipment and our consumables has a direct impact on quality and safety (IP31, CEO, C7N)*

In examining the focus of leaders, it became clear that a healthcare quality focus is not a singular concept and embraces several possible foci. Depending on organisational quality maturity, the focus is on compliance through achieving accreditation and meeting funder requirements, further developing quality systems or striving for excellence in healthcare provision.

At C8, where the organisation was previously under financial pressure and the clinical governance system is immature, the focus has primarily been on accreditation. The CEO feels the organisation is ready to move towards strengthening the clinical governance system.

> *The whole focus of the organisation was on just passing the accreditation. So, a lot of the things that were put in place were sort of band aids. Let's just develop this document… to tick a box. So, policies were developed processes, practices, but nothing was embedded… The next phase was … what's going to carry us forward? We managed to get over the hurdle, but how do we now embed that stuff. And ensure that we are a safe agency and are going to maintain accreditation as business as usual. Not the flurry of activity beforehand. (IP35, CEO, C8)*

However, the CEO has struggled to shift the governance focus, stating,

> *Accreditation was a risk, understandably, two years ago it was a significant risk. And I've had the board review the risk register three or four times a year and in the last two reviews I've put it to them that accreditation shouldn't be on the risk register because we passed organisation wide survey and we've passed periodic review. It should be business as usual. So why waste time focussing on accreditation. "Oh no if we don't pass accreditation we won't be funded. It's a huge risk to us". No, it's not! (IP35, CEO, C8)*

At C1, a well-resourced and mature quality system creates the opportunity to move beyond a compliance focus and towards excellence in healthcare for patients, 'the patient just comes first' (IP5, Board member, C1). An executive director echoes this focus.

> *Our board has been really, you know, I think again I can rate them as 10, because they've been absolutely committed to patient quality and have been eager to hear about it and have given it equal, at least equal consideration with other elements. (IP3, DQ, C1)*

The role of governance leaders in changing or maintaining a strong quality focus was investigated in the interviews. The board chair's influence is evident in cases where the board focus shifts with a change in chair appointment, as explained by managers at the following two cases:

> *The board [chair] before the current one fundamentally changed the way things operate for the better. She really got it, was very driven and changed, changed the way that we did things, changed our place in life basically. Which was what we needed. Because when, she got the clinical side, she actually had a clinical background and she drove the stuff that needed to be driven. So very effective board chair. (IP12, DMS, C3)*

> *We had a [board chair] that seemed, certainly prior to Djerriwarrh, was not interested in clinical governance. His main focus was financial. They paid lip service to it [quality] …We've had a change of leadership and there's certainly been a change of focus (IP18, MQ, C4)*

The influence of the board chair is also evident at C2N where the BQC chair is advised by their board chair that quality is a 'matter for that subcommittee. If there's a problem you will sort it out. I've even had that said to me from the chair' (IP10, BQC chair, C2N). These examples highlight the influence of a board chair in limiting or promoting a focus on quality at the whole board.

It is accepted, in most cases, that the BQC chair has a healthcare quality focus. However, their ability to influence other board members and executives is mentioned less often than that of the board chair or CEO. Their influence is seen to be confined to the BQC as explained,

> *[BQC chair] has been the chair of the quality committee for the whole time I've been here and she's, you know, got a very wise head and got a really good view of governance, a good view of quality of care and has really been able to provide that leadership, I think, for the committee. (IP3, DQ, C1)*

At a couple of cases, attempts to drive a stronger quality focus at the board see the BQC chairing being undertaken by a leader perceived to be more influential. At C7N, the CEO replaces a board member BQC chair and this is explained in terms of,

> *She [CEO] wanted to give the impression clearly to the organisation that clinical governance was her domain as well as the board and everyone's. And that that was her decision, to make quality and safety more obvious to the organisation and she thought that will be a symbolic way of doing that. (IP32, DQ, C7N)*

Similarly, at C5, the board chair became the BQC chair to signal the importance of the work of the BQC. The chair describes the need to 'evolve a level of conversation, the complexity of conversation in safety and quality and clinical governance. So, I became chairman of this committee' (IP24, BQC member, C5).

CEOs are a major influence in promoting a quality focus frequently remarked upon by interviewees. While CEOs bring 'different skill sets and they bring different approaches'

(IP23, DoN, C5), a CEO who pursues a focus on quality clearly influences others' thinking as outlined by the following board member,

> *The other thing that [CEO] made very clear, that quality and safety is everybody's responsibility. And you know in our governance, in our reporting in our patient care it needs to be on the continual improve and safety is a part of that. (IP15, Board chair, C3)*

CEO leadership is seen to influence the engagement of not only board members but also senior management. Staff and board members in more highly engaged cases spoke consistently about the contribution of the CEO in developing a clear, shared focus on healthcare excellence. At C1, the CEO places the quality agenda firmly front and centre in the minds of board, senior clinical managers and non-clinical executive as described by both a manager and a board member,

> *[CEO] has held the organisation to account and sort of, sort of modelled, lead and required everybody to come on board with that… The leadership work around requiring that clinical governance activities be taken sort of seriously, done, followed through and managed in a timely way. Setting up governance and visibility of performance in that area, has I think been some of the important sort of leadership actions that have led to that sort of culture that we see here (IP3, DQ, C1)*

> *I think the chief exec has a lot to do with this…he can either be the person, as the chief exec, that concentrates on the dollars and the finance or you can be someone with a more holistic view of the organisation which is centering on patient quality care that will drive finance as well… So, it's about getting that view and the CEO has had a very, very clear view of that himself. (IP4, BQC chair, C1)*

By focussing on improving healthcare quality at the executive level, CEOs create an authorising environment for quality staff. This is seen through the CEOs' influence on the position of the most senior quality staff member in the organisational hierarchy, their physical location and their access to the executive team, as discussed in Chapter 6.

At C3, the CEO made clear that 'her job is to serve the needs of these three offices [Directors of Quality, Nursing and Medical Services]' (IP12, DMS, C3). Similarly, at C6,

> *I think it's unqualified support and we get that [from the CEO]. There's no problem in my opinion about getting the support that we need for quality. And he'll see that as one of the fundamental things that we have to have, a safe quality health care. (IP28, MQ, C6)*

CEO leadership of a healthcare excellence focus is seen to be more effective when combined with a strong culture of quality improvement in which open communication of issues by managers can occur. As explained,

> *CEO has played a very key role in that and empowering that sense of effectively not targeting the messenger and take it on board for what it is, take it on face value and deal with it. (IP5, Board member, C1)*

CEO leadership varies considerably at cases with different engagement levels. At C8, the CEO wants to pursue a stronger quality system focus, yet his leadership of this agenda is less effective. The quality manager describes this,

> *I felt like [CEO] got it [quality] and he saw that it was important but I didn't see any action to follow that through… he didn't push much and he didn't, you know, I felt very on my own. (IP36, MQ, C8)*

This influences the approach of the quality manager to developing reports, where she states, 'I'm not going to get any feedback on what I do so I might as well just wait to last minute and, you know, throw it in' (IP36, MQ, C8). This contrasts with the leadership style of the CEO at C1 who states,

> *I think that units like mine [quality] can do lots of good work and can establish lots of good work but actually really impact is when the CEO walks and talks it… it models it for the rest of the organisation as well. And he lives and breathes it and you know asks people about it, follows up and it doesn't matter where he goes in the organisation he would enquire about that (IP3, DQ, C1)*

The difference in leadership between C1 and C8 is seen in the CEOs' ability to share the vision for a quality focus and engage staff in activities that further that vision.

The personal attributes of the CEO in being committed, approachable and accessible are mentioned by the three highest engaged cases. This contrasts with four of the five lower engaged cases where the CEO is referred to in tentative terms, either through their isolation from quality staff or lack of engagement with staff generally. Personal attributes are important in enabling a CEO to engage, model and inspire other governance participants to adopt and share a similar quality focus.

In summary, leadership is an important mediator of healthcare governance engagement through promoting and maintaining an appropriate shared quality focus, enabling quality executives to act and ensuring a culture of quality improvement that enables openness of communication.

7.3.2 Aligned leadership

An aligned leadership focus on healthcare quality is found at some cases where key governance leaders shared the same quality focus. This study finds that alignment of leadership focus at the governance level is powerful in driving engagement. At C1, three governance leaders contribute to driving a strong focus on healthcare quality,

> *I [quality chair] had an approach, I had an understanding, CEO was very clear, [board chair] was very clear. So, I think the people driving it were quite, you know, they knew what was what was important. (IP4, BQC chair, C1)*

This leadership alignment is also seen to drive board engagement in quality at C3, as explained, 'we had a very fortunate position of a very effective board chair and very effective CEO who actually could work together' (IP12, DMS, C3). An aligned leadership focus on healthcare excellence is evident at more highly engaged cases (C1, C2N and C3).

At three lower engaged cases (C4, C5, C8), champions for this approach to quality are identified, often in quality or executive clinical positions, but are either not supported by board and/or CEO leadership. For example, at C8, the board chair, who also chairs

the quality committee, has little quality experience, and this is compounded by a lack of CEO influence which results in a focus stuck on compliance and leaves a board member feeling 'we do have to get quality and safety front and centre' (IP38, Board member, C8).

Stability in key corporate governance leadership positions is also found to be important. Leaders are crucial in maintaining a quality focus given inevitable changes to board and senior management composition. 'Boards change. So, you know when we say "the board", it's like this is a static thing and it just isn't' (IP23, DoN, C5). Stable leadership assists in orienting new board members to the quality focus as explained,

> *Some of them [board members] come without much understanding of health services, hospitals. It's mind boggling. So, they do take their lead particularly from the chair and the chief executive. (IP4, BQC chair, C1)*

Similarly, changing composition at senior management level can impact on the quality focus.

> *We've had so much structural change at the senior level. What we've seen is that's had an adverse impact on safety and quality because we brought new people [managers] in who were trying to get their head around…So trying to get a foot in the door to say hang on quality is actually really important has been really challenging for the last couple of years. (IP22, MQ, C5)*

A lack of stability in key leadership positions is notable at three of the five lower engaged cases (C5, C4, C8). For example, at C8 in the years prior to the study, a rapid and repeated turnover of CEO and senior management, including the quality manager, had occurred, along with recent changes to board leadership.

In summary, the presence of stable leadership with an aligned quality focus is an important influence on governance seen at more highly engaged cases in this study.

7.3.3 Effective meeting processes

Effective leadership of meetings is found to influence governance engagement in healthcare quality tasks and is examined in this section through the BQC. Given that

the BQC is the forum at which many healthcare quality tasks occur, effective BQC leadership influences effective engagement in these tasks. While the influence of a BQC chair is less evident in driving a quality focus at the whole board level, their leadership of BQC meeting processes is essential for effective meetings. However, BQC leadership is not just driven by the chair but is a combination of BQC chair and BQC convenor, usually the quality director or manager.

Strong BQC leadership promotes effective communication in 'enabling that time for discussion and open discussion' (IP5, Board member, C1). The skill of leaders in discriminating between 'what don't we need to discuss, it's brief and efficient, and what do we need to discuss' (IP9, Board member, C2N) was discussed in Section 7.2 and highlighted in Box 1 and 2. BQC leaders achieve effective communication through processes of overseeing committee papers, agenda structure, reviewing committee effectiveness and controlling meeting discussions as outlined in the following paragraphs.

Governance meeting papers can be lengthy, with BQC papers varying from 65 pages to 238 pages. Many board members feel overwhelmed by information: 'there is so much data' (IP9, Board member, C2N), and 'to me if feels like way too much (IP21, Board chair, C4). Equally managers acknowledge 'they drown in it, this information' (IP2, DMS, C1). Excessive information limits board members ability to understand the key issues, as explained, 'we do our best and we ask questions but as you probably know it's very easy to be swamped with paperwork, you know snowed with paperwork and it's hard to see the wood from the trees (IP10, BQC chair, C2N).

Appropriately identifying information for decision, discussion and noting on the agenda is also important in enabling efficient and effective meetings: 'there's a whole range of information that goes there that probably should be 'for information' like my report' (IP22, MQ, C5). There is also a role for BQC chair to say 'stop … there's too much information coming to this committee' (IP23, DoN, C5). The chair and BQC convenor play a key role in ensuring data is accompanied by meaningful analysis: 'I want to see the analysis of the data I really don't want to see raw data. We just can't deal with it' (IP9, Board member, C2N).

A BQC chair liaising with the quality convenor 'prior to the meeting to have a discussion about what's on the agenda and if there are any issues' (IP28, MQ, C6) is one mechanism used to manage the agenda. A board member explains,

> *The chair should always prepare for the meeting to know what's there. If there's areas of particular concern or issues, that again might not even on paper appear to be of concern, but there is some background around, want to highlight and spend time on (IP9, Board member, C2N)*

At three of the four higher engaged cases there is evidence of the BQC chair working closely with, or being guided by, the senior quality staffer convening the meeting to shape the agenda and information presented. At C1, the executive quality director is crucial in ensuring clear, logical reporting using consistent reporting structures to facilitate board familiarity and understanding of key areas of inquiry. This contrasts with C8, where the non-executive position of the quality manager renders her with little influence in the organisation. This is most evident by her absence at and lack of involvement in coordinating BQC meetings. As a result, the reporting style at C8 is driven by the individual style of the executive, and their understanding of the purpose of the BQC. Box 2 demonstrates that the Director of Medical Services has a view of governance reporting that is centred on individual medical care consistent with their substantive role undertaken at the organisation.

A BQC chair's control of discussion is found to be important in ensuring effective communication. A key chair role is to ensure conversation does not drift into areas not relevant to governance responsibilities. However, determining relevance is not straightforward as boundaries between governance matters and operational matters are less distinct in practice.

> *The last thing you want is your board interfering with the sort of operations. But having said that the last thing you want is for the board not to know about the operations. So, it's I think trying to develop that balance between true kind of oversight and governance. And really having a sense of what's actually going on out there at the*

> *coal face doesn't match what we think is happening out there. I think is a really important balancing act. (IP21, Board chair, C4)*

The skill of the chair is in determining when discussion of operational matters is appropriate.

> *You drive down into one area and look for some depth and understanding of one particular, whether it's an incident or whatever. So, you get a snapshot there which gives you confidence in how it's operating. But you don't want to be doing that all the time. (IP4, BQC chair, C1)*

At C8, a new BQC chair, also the board chair, is still developing this skill.

> *An operational matter was raised and I [CEO] just said 'We need to be careful that the board don't get into these operational matters' and he [chair] said 'oh I didn't actually pick it up. So maybe if you're feeling that at the meeting you just give me a nudge and right on a bit of paper and say operational and I'll pick it up' (IP35, CEO, C8)*

Similarly, at the C6 BQC meeting observed, prolonged operational discussion between the BQC chair and a senior executive regarding detailed clinical management issues left only a few minutes for presentation of two agenda items containing areas of underperformance. The chair's inability to recognise and contain operational drift resulted in limited time for constructive debate on important quality issues.

The role of the chair in facilitating the participation of all board members is also important. This skill is evident at C1 'the art that (chair) plays in being able to orchestrate that [discussion and debate among board members] you know I'll take my hat off to her' (IP1, CEO, C1). This is in contrast to C8, where an interviewee describes 'our board culture is sort of you know, just interrupt everybody all the time for it. So, effective chairing is quite important' (IP38, Board member, C8).

Chairs also need to have the ability to pick up on important issues and drive further examination. This is described by an interviewee as having, 'the right skills in being able to facilitate a discussion' (IP33, DoN, C7N) when required at meetings. This skill is less

evident in the C7N BQC, as the chair approach is described as, 'seemed to be let's just get through the agenda … there was really no, what I would consider to be areas of focus where you could do a deep dive and have a discussion about what the issues were' (IP33, DoN, C7N). Similarly, Box 2 in section 7.2, demonstrates the failure of the C8 BQC chair to pick on systematic issues identified in the discussion of clinical incidents.

Interestingly, leadership of a key committee process, BQC evaluation, is notable mainly by its absence or ineffectiveness at most cases. Formal evaluation of BQC effectiveness occurred at five cases, is undertaken by survey, and is indifferently viewed by many interviewees. Interviewees comment that, 'the response we get back is nothing enlightening (IP28, MQ, C6) and 'you're never brutally honest are you. So, it's like giving people a reference for a job' (IP24, BQC chair, C5). At some cases the assessment did not result in any perceived change in governance practices and board members were left wondering 'what actually happens afterwards' (IP21, Board chair, C4). At C2N, the format of the evaluation allowed for individual comment and this is found to be more helpful: 'some of the comments were really good and we did change things on the basis of those' (IP10, BQC chair, C2N). The tasks of reviewing committee effectiveness, and reviewing BQC reporting framework (discussed in Chapter 5) are largely instigated by quality staff members convening the BQC.

Governance KSAs are particularly important for effective BQC chair leadership. While the importance of these skills may have been recognised at the level of the board chair there is less recognition of their importance at the BQC level, as demonstrated in section 6.3.2. It is clear from cases that lack of board governance KSAs is an impediment to effective leadership of BQC meetings.

This exploration of effective meeting leadership highlights behavioural leadership processes required to foster communication and governance engagement. The analysis makes apparent that there are several important processes leaders facilitate that represent governance taskwork. These are summarised as:

- Agenda setting and paper preparation
- Reviewing committee effectiveness
- Reviewing reporting frameworks

Structuring meeting agendas and papers is a leadership process that assists effective and efficient running of meetings. Committee and reporting review processes are important in ensuring meeting processes and reporting are meeting the BQCs' key responsibilities. Effective facilitation of these processes is seen more in leaders skilled in governance. These important governance processes are added to the taskwork section of the conceptual framework.

In summary, this section highlights that effective meeting leadership promotes the engagement of participants, drives closer examination of issues and effective BQC communication. Effective leadership is also characterised by leaders undertaking key governance taskwork processes.

7.4 Other behavioural constructs

7.4.1 Decision-making

While decision-making is a behavioural process identified in the conceptual framework, it is not a strong theme in the cases. Most BQCs are required to make recommendations to the board for decision at that level. However, few recommendations from BQC to boards are seen in the document review. Where decisions are noted, they are often related to governance processes such as approving revised terms of reference. Decisions about appropriate action in relation to performance issues are the domain of clinical managers and the board role is one of overseeing the effective implementation of actions. Most actions within BQC meetings are consensus driven requests for further data or changed data formats.

Decision-making is discussed, by interviewees, more in relation to endorsing proposed strategy and plans that usually occur at strategic planning days. However, as there is minimal board engagement in oversight of specific strategic quality priorities seen at cases there is no discussion seen on this at the level of the BQC. The lack of decision making in relation to strategic quality priorities is a clear omission in governance of healthcare quality. This lack of decision making reflects the immaturity of the sector in strategic quality decision making in general (see Chapter 5, section 5.3). Rather than concluding decision making is unimportant in governance of healthcare quality, the research indicates that this area of governance is broadly underdeveloped across the

cases. As such the decision-making construct is retained in the framework as a theoretical construct in need of further exploration.

7.4.2 Reflexivity

A key theme emerging from management interviewees is the value of reflection occurring through the process of being held to account. A manager explains, 'there's something about the process of governance… reporting to people higher up the tree than you' (IP3, DQ, C1). The pro cess of governance forces a closer management examination of the data, 'it makes us do the reports. Makes you look at your stuff' (IP26, CEO, C6). The space created for reflection through developing governance reports enables management to 'really understand what is going on' (IP1, CEO, C1). Developing governance reports with a clear, logical narrative supported managers in picking up issues, as outlined, 'it makes us go "oh my God why is that. Okay let's go back, let's look"… and fix things where they need to be fixed' (IP13, DQ, C3). A CEO explains,

> *They'll [the board] influence, influence a stronger look in a particular area. And I think that's very valuable and it might be, not that we're not focused on it, but we know we've got forty balls in the air (IP11, CEO, C3).*

Effective board questions also prompt valuable reflection and encourage managers to look at data from a different angle and move away from an operational perspective to 'broader accountability for patient safety and quality' (IP13, DQ, C3). The different perspective gained is explained by the following interviewees:

> *I know that having to read a report that I'm going to have to present to the quality committee I see it through different eyes … So, they ask different questions. They're not in the business so much but they have this governance responsibility and I can have, so our report goes through many committees as you've seen. So, I can have seen the same report four times on its way up the tree. And by the time it gets to the Quality Committee I'm going oh my goodness, look at that, because it's different eyes, they come at it with different eyes. (IP3, DQ, C1)*

> *It gives you another point of reference I think to. So, it's almost like a triangulation thing. It gives another set of eyes, who aren't part… of the bureaucracies or the apparatus. So, they bring fresh views and ideas. (IP8, Manager, C2N)*

The governance process of being held to account is valuable in creating a space for managers to stop and reflect about the meaning of quality data. Reflection is facilitated by both the process of report development and through effective board questioning and challenge.

Reflection on the effectiveness of governance processes is also found to be valuable in the study. Reviewing reporting content and format (see Chapter 5, 5.2.5) and reviewing BQC committee effectiveness (see Chapter 7, 7.3.3) are processes that promote reflection among board members and managers around whether healthcare quality governance responsibilities are being fulfilled.

Reflexivity is an important behavioural process in fostering greater insight into quality issues and governance practice. Reflexivity is more often experienced and identified by interviewees in more highly engaged cases.

7.5 Affective emergent states

The influence of the board management relationship on governance engagement in healthcare quality tasks is explored in this section. Trust, respect, cohesion and conflict are constructs identified in the conceptual framework and investigated through questions in the semi-structured interview and through observation. The benefit of mutual trust and respect is apparent in cases. Conflict is notable by its absence at more highly engaged cases and high or low levels of familiarity or cohesion are found to negatively influence engagement. These constructs are explored in the following sections.

7.5.1 Trust

Trust is frequently raised by interviewees when discussing the board management relationship. The approach to communication is important in a board developing trust with executive, as reflected in this comment 'what is it that makes this a board that

trusts the executive? What is it? It's not because we all play tennis after hours you know. How is that communication managed to do that?' (IP39, Board member, C8).

Board members trust of executive relates both to the transparency of communication and perceived competency. Board members rely on executives to provide appropriate information to enable governance oversight of healthcare quality performance,

> *One of the assumptions you always make is [the board is getting] the right KPIs. How do you know? Like I mean that, where you have someone like [Quality Manager] where you have to trust that they are the right set of KPIs (IP24, BQC chair, C5)*

As outlined in Section 7.2.2, a strong commitment to open transparent communication is seen in several cases. Transparent management communication, in reporting underperformance, in these cases plays an important role in fostering trust in management and give boards 'a lot of comfort' (IP4, BQC chair, C1). As this interviewee notes, 'it has helped to improve the trust because they [board] know that they'll be told if there's an issue (IP13, DQ, C3)'.

Evidence of executive competence contributes to building board trust in executive.

> *Our organisation is pretty stable. The board obviously trusts us, but if you have a few disasters and you've run out of money and the department is on you. Then the board relationship is tougher. (IP26, CEO, C6)*

At C8, where the organisation had been under performance watch, the expression of trust is more tentative, 'it's not a bad relationship, they [board] feel free to question us … And I don't think the executives are intimidated in any way' (IP35, CEO, C8).

Managers also need to trust board members. However, the emphasis is more on the need to feel safe in exposing areas of underperformance. A focus on improvement, rather than a blame culture is seen as crucial to transparent communication by managers. A quality improvement culture is described by a board member as, 'let's treat it [underperformance] as an opportunity rather than a criticism' (IP21, Board chair, C4).

This trusting governance environment is mentioned frequently by interviewees at higher engaged cases, as

> *So, I think that is the culture within them, within the[board] attendees of the [BQC meeting] there is really about 'We're here to support you to realise what we want you to realise' rather than being, they can judge, they can make an assessment as to whether it's not [it is optimal performance]. But it's in the improvement and delivery of success rather than acknowledging failure. (IP1, CEO, C1)*

Previous conflict at the governance level and financial stress at C4, had damaged the feeling of management safety through a culture that is described as 'we probably weren't going down the no-blame culture' (IP16, CEO, C4). The interviewee goes on to explain,

> *We haven't gone full bottle on being quite open and transparent, that kind of thing. That's the next level of maturity. And I'm not sure. That's going to take some time to get there. So, look to me it all comes back to trust. (IP16, CEO, C4).*

Interestingly, several interviewees comment on issues of trust when clinical leaders report to the board. Caution or resistance to full transparency sometimes occurs when clinician managers report their program's performance at the board table.

> *People are really used to their financial performance being publicly visible being reported on at, you know, having to explain the variation there, even used to having to explain the variation on access performance. But quality of care around patient safety, patient experience and patient outcomes they're not so used to … So, I think it's been over the last five years we've had a lot of sort of what I would describe as sort of push back, resistance and questioning about why we make [managers report]. People think that, people think we are publicly naming and shaming them (IP3, DQ, C1)*

> *It's difficult to want to, to look at clinical incidents because the [clinicians] always feel guilty about it and they defend their colleagues.*

So, they don't have that culture, let's learn from this and improve it. They are the classic data doubters. (IP38, Board member, C8)

The concept of safety is equally important in enabling board members to feel comfortable to ask questions. As one interviewee notes, 'I think as long as the culture's right, the nonclinical people [board members] will particularly ask the question, explain this to me' (IP11, CEO, C3). A manager further explains,

Sometimes I actually think they [board] feel more uncomfortable than … we do. And so, I think it's our job to reassure them that they should give us those questions. (IP23, DON, C5)

The role of leaders in promoting a focus on improvement associated with a just culture and openness of communication is essential in building a safe, trusting environment for underperformance to be revealed at the board table and challenging questions to be asked.

7.5.2 Respect

Interviewees frequently used the term 'respect' when discussing the board management relationship. Board members often express respect for executives and managers in terms of acknowledging their 'knowledge and skills' (IP21, Board chair, C4). Executives welcome the board's recognition and 'respect for people's expertise' (IP17, DMS, C4). In some cases the board is found to be 'highly respectful. I think that they [board] are very acknowledging' (IP3, DQ, C1).

Management respect for boards is less frequently mentioned and originates from a few higher engaged cases only. At C1 and C3, both management and board interviewees consistently identify management respect for the board.

There's this enormous respect from the management team for the board members and even for the stupid questions and no one feels that they can't ask those questions (IP4, Board member, C1)

We're all really respectful of our board. They're a great group of people. They have really good opinions here. They're all got their own talents and I think we all respect that (IP13, DQ, C3)

At these cases interviewees report that CEOs set clear 'expectations that we are respectful of the board, that we understand that they're the highest level of governance in the organisation and that we treat that with the sort of respect and consideration that it ought to be given' (IP3, DQ, C1). This involves an active program of promoting the board as one CEO explains,

> *Part of my job is … promoting the role of the board so in my newsletter every month I always do a thing about where the board were visiting and what they're doing …You know making sure that each board chair brings their own kind of angle. Making sure that some of those kind of key things about the importance of good relations, the importance of connection, the importance of respect, making sure that all comes together. (IP11, CEO, C3)*

The other factor seen to influence management respect for board is the perception of skills board members brought to their governance role. Board members with clinical backgrounds are generally awarded executive respect, as a clinical background is seen as giving 'a little bit of credibility' (IP24, BQC member, C5). This is evident at C2N when a manager states '[BQC chair] is still clinically active obviously and so I have the utmost respect for her' (IP8, Manager, C2N). Respecting board skills is not restricted to clinical area and governance skills are recognised, as discussed in Chapter 6 (see 6.3.2).

While all interviewees at C1 mentioned respect, at C8 respect is not mentioned by any of the five interviewees. Questioning of others' skills and knowledge is more apparent at C8. A board member questions other board members' skill. 'It's difficult to get the right skills mix just from local people' (IP38, Board member, C8). Management questioning of board members also occurs as shown by this interviewee,

> *He's [board member] a [specialist], that's not a real doctor. When it comes to medical issues which is what most things are, even for someone like [board member] he doesn't know whether that should or shouldn't happen (IP37, DMS, C8)*

The board is also seen to question executive skills as shown in the response by a board member stating,

> *The CEO we work with is a challenge and I don't think the board has the skills to manage him and I think we could manage him much better and get more out of him. (IP38, Board member, C8)*

At C6, where there is a similar failure by all interviewees to mention respect, concerns expressed by management about board member skills include the following,

> *We have to tell them. They can't work that out. Look I work 60 hours a week and I've probably done 6-8 years at university training on this. The view of the department has that the strategic objectives and agenda is set by the board is actually not true. It can't be true. They actually don't know what they are doing. (IP26, CEO, C6)*

> *Something has to be done and if we can't change the board members [on the BQC] we probably need to bring in an external expert. (IP27, DQ, C6)*

Mutual respect, 'an appropriate way between board and senior executive … a relationship built on respect and trust' (IP9, Board member, C2N), is more commonly expressed in cases with a higher engagement score. An interviewee further explains,

> *They [board] have an expectation about the information they require and of how we as the executive support them to be able to do their job. And so I think I think I would say it's a sort of highly respectful relationship where we value the contribution that each makes. (IP3, DQ, C1)*

The presence of 'quite a degree of mutual respect' (IP5, Board member, C1) existing at C1 and C3, is related to individual KSAs and an active strategy of promoting a respectful management attitude to the board. Respectful relationships at more highly engaged cases, such as C1 and C3, exist alongside an approach to communication where board members feel comfortable to ask questions and challenge management, and managers are transparent in their communication.

7.5.3 Cohesion

Cohesion was explored through asking interviewees to describe the board management relationship. Cohesion at the board table is seen by some interviewees as vital in building a good working relationship, 'the importance of good relations, the importance of connection' (IP11, CEO, C3).

Familiarity through spending time together via formal mechanisms, such as regular attendance at meetings, promotes cohesion. At C7N, where executive staff exposure to the board is limited, an executive remarked 'there's only a couple of the other board members that I know remotely well because I have nothing to do with them' (IP33, DoN, C7N). Cohesion varies with changes in board and executive composition, as explained,

> *'All of a sudden your CEOs gone… And then your board has also got some changing. And you know, you move and then you're moving into that space of unknown … I think it's still having an impact. And I don't think we'll move to that next level of Board executive discussion until everyone feels a bit more secure'. (IP16, CEO, C4).*

Opportunities for fostering cohesion are created at some cases through informal social gatherings such as, 'we have morning teas after our board meeting. So, the management group's there and then they bring some of their team along' (IP4, BQC chair, C1). Cohesion is also seen to be promoted through governance events that occur outside of the structure of board or committee meetings, such as annual strategic reviews. These events provide opportunities for discussion and exchange between board members and executive. The following interviewee describes the benefit of understanding other board members perspectives.

> *We've got a chance to actually really talk about our beliefs about health and wellbeing and what's important and what really matters and our experiences… we got to be people with experience and knowledge that we brought to our board role in a different way from just in our functional capacity. So, we got to know each other. (IP9, Board member, C2N)*

These activities provide opportunities for exchange that do not exist within the confines of a tightly structured board, and in committee meetings.

At C8, a lack of cohesion among management is evident. The most recent quality manager had been at the organisation 9 months and had never met the part-time director of medical services. The quality manager had also never attended a BQC meeting and was not familiar with the board members. Relationships between board members and executives who attended the C8 BQC meeting appeared to be cordial, with a relaxed and friendly atmosphere noted when observing the BQC meeting. However, this atmosphere appeared at times to be detrimental to governance. At several points when discussing issues of underperformance, including a case at which patient mismanagement almost resulted in patient death, several comments resulting in group laughter, acted to curtail more detailed discussion.

In contrast, at C1, the board and management relationship is described as 'collegiate. It is open' (IP1, CEO, C1). At the observed meeting, while the relationship appears strong and respectful, there is a gravitas about proceedings, a tone of serious inquiry and listening rather than friendliness. The distinction between a productive relationship and friendship is commented on by the following CEO, 'we're not all trying to be buddies. We understand they've got their job and we've got our job but there's a lot of conversation, a lot of conversation (IP11, CEO, C3)'.

Governance cohesion is evident in more highly engaged cases where the role of the board and management is understood, respected and acknowledged. As explained by this interviewee,

> *I think it's really a constructive working relationship. I think that everyone's kind of clear about what they're there to do and the role that they play. And so I have never found anybody more than really willing to respond to any of my queries. They know where I'm coming from … sometimes it's a very naive question. Hang on a minute why is that like that or … more a procedural or governance question. Then they know that that's what we're there to do. I find the managers really very*

responsive, very collegial. The working relationships are good. (IP9, Board member, C2N)

In addition to time spent together, reciprocity of communication is perceived to be important in promoting a cohesive relationship.

I would almost say we don't have a relationship … I'm there to provide them [board members] with information … it's one directional, it's not an exchange. (IP28, MQ, C6)

Opportunities for exchange between board and staff at the BQC are more limited where there is a low proportion of board members to staff present.

It's one of those ones where I feel like the people, are different types of people and they are obviously being very accountable for the work they do. But I don't get that sense of incredible collegiate as some of the other committees… I can just feel it's a very different dialogue so they have their own conversations a lot and it's just making sure that you feel like you've got to get your voice in there as well. (IP25, Board member, C5)

The lack of reciprocity between board and management is particularly evident at the observation of the C7N BQC meeting where the conversation is dominated by the 37 management and clinical staff.

In summary, for cohesion to develop, participants need opportunities for the exchange of views, both in the formal meeting settings and in informal settings to explore and understand each other's perspectives. An appropriate level of cohesion, underpinned by an understanding of respective roles, influences effective working relationships between board and senior management and is more evident in higher engaged cases.

7.5.4 Conflict

Conflict at the board table is rarely experienced by interviewees. C4 is the only case to experience damaging relationship conflict between the board and senior management, as explained,

> *Working together is paramount and particularly the chair and the CEO must have those relationships around trust and openness and transparency. And that's probably something that we have struggled with over probably the last three to four years … [Former CEO] and the previous chair didn't get along. And they worked hard at trying to do it. There was always this personality clash (IP16, CEO, C4)*

The tense relationship, felt broadly by mangers, is described as, 'when he was [chair] of the board, there was speak when you are spoken to. And it was, it just killed all quality conversation at that meeting [BQC]' (IP18, MQ, C4). This conflict led to reduced management transparency and openness of communication with management 'say[ing] as little as possible in the meeting' (IP18, MQ, C4). With a change in chair the relationship and style of communication is described as changing,

> *It's a good open discussion with views put backwards and forwards. And you know respect for people's expertise and yes if the consensus is that we, consensus rather than a direction, is that it might be beneficial to do something or other [then] we'll go off and do it and have a go at it. (IP17, DMS, C4)*

The only other reference to conflict mentioned in interviews relates to tension between clinical managers at the board table. This is described as, 'the only people you would see tension between would be doctors' (IP33, DoN, C7N). These professional tensions exist alongside tension between clinicians and managers where clinicians' view of their professional autonomy and the bureaucratic accountability requirements of senior management collide. Several executives talk about actively managing tensions to prevent staff conflict at the board, 'I think there is some etiquette that there shouldn't be that [conflictual] discussion. There's operational discussion that needs to be had before you go to [BQC]' (IP18, MQ, C4). Most conflict is seen to 'play out much more at the executive level' (IP3, DQ, C1). However, occasionally conflict is described as, 'some of it gets escalated up to the board' (IP3, DQ, C1). When this occurs conflict management skills are required to 'sort out what is the conflict here. How do we deal with it now? What's appropriate for this meeting and what needs to then become an additional discussion with a particular focus? (IP9, Board member, C2N). A lack of chair skills, at C8, in dealing with conflict is described,

> *We had a famous incident when one of the GP's rattled off to the chairman of the board in the [BQC] committee, problems about [facility] and [said] the " board has no idea what they are doing and they're going to close it down and we need a proper plan" and I was saying to the chair 'This is not the place for this. Tell him to write it down and we'll discuss it as a board' (IP35, CEO, C8)*

While conflict was largely avoided between board members and managers, interviewees recognise the value of a 'healthy tension' (IP11, CEO, C3) between board and management. This constructive tension is not 'overt' (IP4, BQC chair, Board, C1) and in healthcare quality governance is expressed as a subtle but persistent focus on 'the data and about the presentation. And about holding the organisation to account around safety and quality' (IP23, DoN, C5). The C1 Director of Quality gave an example of constructive tension when the board pursued more information about suicide rates in psychiatric services, over a considerable period, until it was satisfied it was getting the information it needed.

This constructive tension between board and managers is seen as helpful in preventing people 'thinking the same way' (IP23, DoN, C5) and sharpening the focus at the governance level. At C3, the CEO actively fosters a constructive unease or a 'constant sense of vigilance' (IP11, CEO, C3) with the current state of quality as outlined,

> *Yes, celebrate achievements but understand that we're in [a] really dangerous game, you know. And yes isn't that great that 85 percent were really happy. But that 25 [15] percent that weren't. So, make sure that half of the glass, half empty stuff gets plenty of focus. And I think that's that thing. We're in a dangerous business. We are harming patients. Even on a good day we're harming people (IP11, CEO, C3)*

In summary, conflict, while occurring at cases, is less apparent at the board table, with one exception at C4, where conflict negatively influenced engagement. In cases with good board and management working relationships, constructive tension around the status of healthcare quality works to sharpen the governance focus and drive challenge to prevent complacency.

7.6 Cognitive emergent states

A shared understanding of governance roles and objectives are constructs in the cognitive emergent state category in the conceptual framework. The formal expression of governance objectives and roles was explored through TOR in Chapter 6, and the practical expression of this was examined in Chapter 5, through engagement in taskwork. This section addresses the extent to which governance participants share the same understanding of objectives, roles and tasks.

A shared understanding of the broad objective of healthcare quality governance is evident among cases. When interviewees are asked about the board's role in governing healthcare quality, almost all board and management interviewees articulate the overall aim of governing healthcare quality either in terms similar to 'we're here to make sure people are well cared for (IP25, Board member, C5) or to make sure 'that this is a good quality health service which is safe'. (IP24, BQC chair, C5)

On the other hand, there is a variable understanding of roles and responsibilities as outlined in the following sections.

7.6.1 Shared understanding of role and tasks

Beyond a broad aim of improving quality and safety, board respondents are less certain about tasks related to their role in governing healthcare quality.

> *I think every board member would put their hand on their heart and say, 'Yes this is a really significant part of our role. Probably the most significant part of their role. So, I think they've got that kind of attitude or value really clear in their minds. But I think we all struggle with how you actually do it. (IP21, Board chair, C4)*

Executives echo this view of board members 'struggling with' (IP17, DMS, C4) understanding key tasks related to their role.

> *None of them [board members] would dismiss the importance of quality and patient safety. But I think it comes down to their*

understanding of what that is and what they need to do as board members for that. (IP7, DoQ, C2N)

When asked about key tasks in governing healthcare quality, all interviewees identify one or more processes related to the task of evaluating healthcare quality. Many board members describe this task in terms of monitoring quality data or 'making sure there is a clear line of sight with key metrics' (IP25, Board member, C5). Other processes related to this task, such as endorsing information for reporting, identifying underperformance and monitoring action implementation, are less frequently mentioned. This narrow understanding of this task is reflected both in the review of TORs (See Chapter 6, 6.4.3) and in the limited engagement in the full range of processes related to this task of evaluating healthcare quality (See Chapter 5).

Interviewees mention monitoring safety more frequently than other dimensions of quality healthcare, when discussing the task of evaluating healthcare quality. As described by this interviewee,

So, when I talk about quality. What does it mean? … I think it's essentially the board is there to make sure that at every level possible we're doing everything we can to keep it safe. (IP25, Board member, C5)

While safety is arguably the most important aspect of quality, a focus on safety reflects a lack of shared understanding of the term quality healthcare. As discussed in Chapter 5, agreeing a quality definition is a key process in the task of evaluating healthcare quality. Shared understanding of the multidimensional nature of quality is generally lacking at most cases, as explained,

Quality is more than just safety. But I think actually as an organisation we are still early in our journey in exploring all the dimensions of quality. (IP10, BQC chair, C2N)

The lack of shared understanding about the meaning of quality healthcare reflects the lack of measurable quality definitions found in the documentation review (see Chapter 5, 5.3.1.).

The boards' role in the task of overseeing quality strategies or priorities is infrequently mentioned by board members. Again, this reflects the findings in the review of TOR and in governance practice observed. However, there is a real appetite expressed by management for board involvement in 'setting strategy and monitoring that' (IP23, DoN, C5) and driving 'long term underlying strategy' (IP16, CEO, C4). This manager further explains,

> *Going forward it would be the key committee [BQC} that I, with [CEOs] agreement that we actually need to start working on more. What would this look like, so if we developed a plan about how we can transition to strategic quality I would see they would have a big oversight role and having a board input into that? With the high level people going to the board with a very clear this is, that's what we propose to do. Do you agree? (IP22, MQ, C5)*

Management are more likely than board members to mention this task of overseeing quality priorities.

> *They set the culture, they set the strategy and they set the environment in which you know an absolute requirement for quality of care is you know must be there. (IP3, DQ, C1)*

The failure of board members and staff to share a clear understanding of the range of tasks and related processes of healthcare quality governance is apparent in most cases. A lack of shared understanding of processes related to the task of evaluating healthcare quality and the task of overseeing quality priorities reflects the incomplete representation of these tasks in BQC TOR and in practice. This suggests that TOR and other guidelines have a role in increasing governance participants' awareness of their role and specific tasks to be undertaken. The evidence in the study demonstrates that a shared understanding of roles and taskwork is reflected in the engagement in these tasks.

7.6.2 Understanding BQC role

When asked about the BQC role, some interviewees see the committee as a place where the 'laser focus' (IP5, Board member, C1) or 'deep dive' (IP25, Board member, C5) or

'heavy lifting' (IP20, BQC chair, C4) of governing healthcare quality occurs. This is described further,

> *I think it's the place where we deliver them much more detail .... so, the board gets the scorecard and the quality committee gets a much more detailed view of the quality of clinical care of the organization. (IP3, DQ, C1)*

However, at some cases the BQC role is felt to be less clear.

> *The committee itself is immature. Because it's just a committee that receives information and doesn't understand what it should be doing with it? (IP35, CEO, C8)*

This lack of shared understanding of the C8 BQC role results in a focus on operational information.

It is apparent in this study that NSW cases view the BQC role through a different lens. NSW BQC meetings are observed to be more operational in nature than most Victorian cases. Box 3 below provides an example of the C7N BQC meeting that was observed

The C7N BQC meeting was attended by 39 participants, mainly clinical and program directors. The meeting was held in a large room with a seating arrangement that did not allow all attendees to sit at the table and resulted in a second row of meeting participants, which included one non-executive board member. The former board member chair of the meeting was invited to sit next to the new chair, the CEO, but declined. Executive board members were present at the meeting but it was not clear who they were.

The CEO mainly directed questions to staff. The CEO proposed action and several times asked 'is everyone comfortable with that' to which a few murmured assents were taken as approval of a decision. Participant engagement was largely passive and subdued with contributions made in response to questions directed by the CEO or occasionally in response to open questions. On one occasion the CEO sought input from board members but none was provided. The meeting was characterised largely by information dissemination, e.g. new software for patient experience, and a detailed patient case study rather than a broad analysis of quality and safety.

Box 3: C7N summary observation notes BQC meeting

The observed operational focus of the C7N BQC is confirmed by a board member, 'the councils are really a part of the management structure of the hospital… a number of the board members are members and attend to provide the linkage but it's an operational drive' (IP34, BQC chair, C7N). A similar view is expressed at the other NSW case.

> *It's where the Director of Clinical Governance [DCG] reports to the CE and it's basically the DCG's meeting. They're in charge of the agenda and blah, blah, blah. So, you're there to help the chief executive understand the clinical issues and identify any clinical concerns… And I've always understand that to be the role of the meeting. … So, it is an operational meeting in that sense. (IP10, BQC chair, C2N)*

The understanding of NSW BQC as being more operationally driven relates to the historical and legislative arrangements discussed in Section 6.6.4.

In summary, the extent to which there is a shared understanding of the BQC role is seen to vary between cases. Shared understanding of the BQC role, where evident, is seen to differ between states reflecting historical practice. The extent of and/or the nature of shared understanding in turn influences engagement in governance processes.

7.6.3 Understanding Board role

When discussing the board, many interviewees mention their role in creating 'an environment of accountability' (IP3, DQ, C1). As a board member explains,

> *I think our role is to make people accountable by the fact that they have to delve into their results and they have to bring some vital information and maybe excuses or maybe reasons why things happen. (IP30, Board member, C6)*

While managers refer to a board's accountability role, they also see the importance of the board and managers working collaboratively on key issues. This is highlighted by these interviewees:

They're not just there for exec to be accountable. They're part of the conversation. So, it is very much around the asking of questions, the considering of this, of where this is in terms of our strategic direction. (IP11, CEO, C3)

This is the bit they [board] probably would need to say, to articulate to the executive. 'We're in this together' … you've got to be held to account. I have no problem with that. But the decision making has been done together. On some of these big-ticket items. (IP16, CEO, C4)

This collaborative view of the board and management in governance work is not mentioned by board members in interviews. This divergent understanding of the board and management relationship may explain why managers are seen to drive many of the healthcare quality and governance processes. Board members tend to have a more passive view of governance, as expressed in receiving and monitoring information to inform accountability requirements. Whereas managers see the need for board members and managers to work together in activities to identify priority areas and pursue issues that drive better healthcare quality.

7.7 Chapter 7 Summary

This chapter addressed teamwork mediators of governance engagement in healthcare quality tasks and processes. Constructs within behavioural processes, affective and cognitive emergent states categories within the conceptual framework were explored via case studies and all were found to be relevant to the healthcare governance setting. The analysis of behavioural processes also identified an important emergent teamwork construct influencing governance effectiveness, reflexivity, and this is added to the behavioural process category. Also emerging in the exploration of behavioural processes were key governance processes that were important in fostering engagement that are added to the governance taskwork category. These changes are reflected in Figure 11.

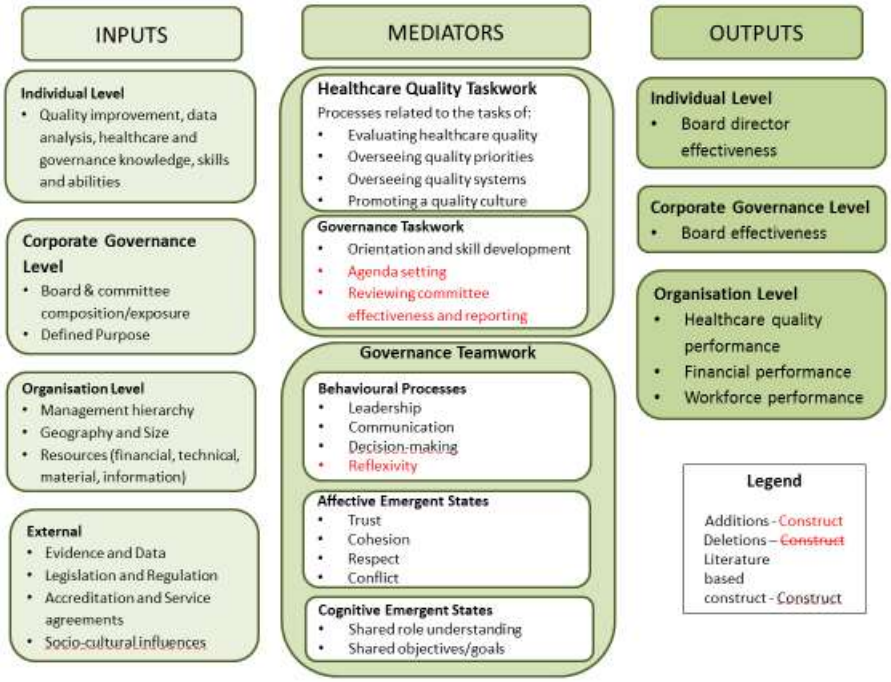

Figure 11: Changes made to conceptual framework from Chapter 7

Communication and leadership are found to be major teamwork influences underpinning governance engagement. This chapter progressed the understanding of these constructs, beyond their brief acknowledgement in the literature, to explain how they advanced governance engagement through outlining key elements of each construct.

The interconnectedness of teamwork mediating constructs is evident in the findings. Leaders that clearly understand their role and display strong leadership skills promote a clear focus on improving healthcare. They can lead board and management participants in robust, respectful and open discussion of healthcare governance and engagement in key processes of governance and healthcare quality taskwork.

A detailed exploration of constructs in the conceptual framework influencing engagement in governance processes was undertaken in this chapter and in Chapter 6. Modifications required to the framework, as a result of analysing constructs, were noted in these two chapters. Chapter 8 brings together the empirical findings of these

chapters to present the revised conceptual framework. Chapter 8 also explores in greater detail the interplay of constructs shaping engagement.

Chapter 8 Discussion

8.1 Introduction

In this chapter the conceptual framework is revisited in light of the empirical evidence presented in this thesis. Evidence presented in the previous three results chapters highlights that many constructs in the original framework are relevant. However, several modifications, deletions and additions are made to constructs. This chapter brings together those refinements to outline constructs found to influence effective governance of healthcare quality in Australian public hospitals in a revised framework, the Healthcare Governance Performance Framework.

Changes to framework constructs in the taskwork, input and mediator categories are reviewed. These include the addition of the governance taskwork category, the identification of evidence as an important input and the recognition that reflexivity is essential in fostering effective governance. Communication and leadership constructs are elaborated in greater depth and the influence of power is found to be diffuse rather than a construct operating at only a corporate governance level input. Modified or emergent constructs are compared with the existing literature to highlight contributions made by this study. While output constructs are not formally tested in the framework, the challenges in accessing robust organisational level measures of healthcare quality, especially in the Australian context, are discussed. This highlights the value of developing more proximal measures of governance effectiveness.

Communication and leadership, important factors influencing engagement, are then used to highlight the complexity of interactions occurring between constructs to shape healthcare governance. A unique combination of constructs is found to interact at each case, indicating that influences on engagement are context specific and reflect an organisation's characteristics and the environment within which it is situated.

Ultimately, the contribution this thesis makes is, firstly, to provide a more detailed understanding of processes of healthcare quality governance than previously presented in the literature. Secondly, this thesis demonstrates input and mediating factors influencing engagement in these processes, some of which have received little attention in the existing literature. The HGPF, for the first time, brings together a comprehensive

range of constructs found to influence effective governance of healthcare quality in Australian public hospitals. In so doing, the characteristics of effective corporate governance emerge and are described as engaged, focussed, vigilant and reflective. The chapter concludes by outlining fundamental and aspirational principles to assist health services in strengthening their governance of healthcare quality.

8.2 Reviewing taskwork constructs

The first research question, addresses how boards and managers undertake the work of governing healthcare quality. In the empirical work, I examined this through a detailed analysis of processes in the taskwork category of the conceptual framework. The literature review (see Chapter 2) outlined a focus in surveys on a limited range of governance taskwork processes that are typically quite straightforward to assess (such as the presence of a board scorecard or dashboard). When cases in this study are compared based on their participation in these commonly cited processes, their level of engagement is broadly similar as show in Table 27.

Commonly cited processes	**C1**	**C2N**	**C3**	**C4**	**C5**	**C6**	**C7N**	**C8**
Evaluating Healthcare Quality								
Board quality committee exists (Jiang et al., 2009; Jha & Epstein, 2010; Prybil et al., 2010; Jiang et al., 2012; Jha & Epstein, 2013)	✓	✓	✓	✓	✓	✓	✓	✓
Board regularly review quality healthcare performance (Vaughn et al., 2006; Jiang et al., 2008; Jha & Epstein, 2010; Prybil et al., 2010; Jha & Epstein, 2013; Mannion et al., 2015)	✓	✓	✓	✓	✓	✓	✓	✓
Board uses a quality scorecard or dashboard (Kroch et al., 2006; Vaughn et al., 2006; Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012; Bismark et al., 2014)	✓	✓	✓	✓		✓	✓	✓
Trending and benchmarking performance (Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012)	✓	✓	✓	✓	✓	✓	✓	✓
Board Agenda has an item on quality (includes quality agenda item or quality directorate report but excludes BQC minutes) (Jiang et al., 2008; Baker et al., 2010; Jha & Epstein, 2010; Bismark et al., 2014)	✓	✓	✓*	✓*			✓	

Overseeing Quality Priorities								
Board has established or endorsed goals relating to patient outcomes (Jiang et al., 2008; Baker et al., 2010; Jha & Epstein, 2010; Bismark et al., 2014; Mannion et al., 2015)	✓	✓	✓		✓	✓	✓	✓

Table 27: Comparison of engagement levels based on existing literature

Table 27 does not include two commonly cited processes of healthcare governance; objective measures for healthcare quality in the CEO performance review (Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012; Jha & Epstein, 2013; Mannion et al., 2015) and time spent on quality at the board (Joshi & Hines, 2006; Vaughn et al., 2006; Jiang et al., 2009; Baker et al., 2010; Jha & Epstein, 2010; Prybil et al., 2010; Bismark et al., 2014; Mannion et al., 2015). Data related to CEO performance measures was not collected in the study as access to CEO performance review documentation was not available. Exposure to quality via the BQC, rather than time spent on quality at the board, was used in this study as the BQC was seen as the main forum for most healthcare quality governance processes.

For the six processes that data is available for, it can be seen from Table 27 that cases vary little in their engagement in these processes. This is consistent with the findings of Freeman et al (2016) who found that commonly cited governance processes are not useful for discriminating between health services. The frequency with which most cases undertake these governance processes reflects a form of institutional isomorphism. Institutional isomorphism is the process by which organisations become more similar (Karlsson, 2008). Mimetic institutional isomorphism is characterised by organisations who may deal with uncertainty by adopting pre-existing processes used by peers perceived to be high performing (Karlsson, 2008). In much the same way that healthcare boards adopted models of governance from the corporate world with the accompanying focus on financial accountability, there has been a similar isomorphism in the area of healthcare quality governance. The lack of understanding of processes to support effective oversight of healthcare quality, has led to a focus on a narrow range of governance processes that have been highlighted in literature and guidelines. These common processes, , have been adopted broadly over the last few years and have lost

their discriminatory power. Undertaking these commonly cited processes does not equate to effective taskwork. They do not adequately represent the range of healthcare governance processes that boards need to engage with to effectively achieve taskwork objectives.

A detailed examination of the work of boards and senior managers, via qualitative methods in Chapter 5, made visible many additional processes in relation to the two key tasks of healthcare quality governance examined, evaluating healthcare quality and overseeing quality priorities. This finding makes clear that it is not just engagement with taskwork that is important, but the quality of that engagement. Effective engagement in taskwork is predicated on how well the various processes, related to each task, are undertaken.

Healthcare quality processes described in Chapter 5 are, in this section, compared to the existing literature to highlight the contribution made in this thesis to understanding taskwork. The first task examined, evaluating healthcare quality, is often presented in a passive way in the literature. For example, the board 'reviewed a quality dashboard' (Jha & Epstein, 2010, p. 185) or 'regularly receives formal reports' (Prybil et al., 2008, p. 31). Reviewing data does not by itself equate to effective evaluation. Chapter 5 highlights additional processes, receiving little or no attention in the literature, that need to be undertaken to effectively evaluate healthcare quality. Processes of selecting and reporting appropriate data and identifying performance variation and action required are all found to be necessary in effectively evaluate healthcare quality and are discussed below.

Healthcare quality is a multi-dimensional concept requiring a range of measures to inform its evaluation (Hibbard & Pawlson, 2004). There is relative silence in the literature concerning how appropriate quality data is selected to reflect the multi-dimensional nature of quality. In surveys of governance activity, a few questions typically address the use of specific data types such as sentinel events (Jiang et al., 2009) and patient satisfaction (Jiang et al., 2012) without exploring data selection approaches. In this thesis, the process of defining measurable dimensions of quality is found to be important in identifying types of data for board reporting. Using these dimensions in structuring reports is also found to be helpful. Normative literature reflects this finding

through suggesting that using conceptual categories to structure reports promotes understanding and familiarity with key quality concepts (Agency for Healthcare Research and Quality; State of Victoria, 2009, p. 9).

At more highly engaged cases, data selection was carefully considered through periodic formal processes of reviewing reporting. While the value of regularly reviewing data selected to inform the evaluation of healthcare quality has been identified by some studies (Joshi & Hines, 2006; Kroch et al., 2006; Levey et al., 2007), the literature has largely been silent on how this happens. This study found data review processes are facilitated by the presence of detailed calendars of reporting and/or detailed indicator frameworks that make transparent the targets and their derivation, and rationale for changes to indicators or targets.

When addressing healthcare quality reporting, the extant literature has focused on the presence (and to a lesser extent the content) of board dashboards (see for example Jiang et al., 2009; Jha & Epstein, 2010). However, this thesis demonstrates that the main board dashboard is not a reliable indicator of healthcare quality data reported at the governance level for two main reasons. Firstly, cases were found to have more than one dashboard at the board and committee level. When these additional dashboards were considered, there was less variation observed between cases in indicator content. Secondly, dashboards reflect a limited range of information, often with a focus on indicators derived from state department of health performance measures.

As Goeschel et al (2011) observe, a limited focus on the presence or content of dashboards or scorecards does not inform what other information the board gets or how this information is used. In the case studies, variation in selecting and reporting quality data is more evident in stand-alone reports than dashboards. Differences are observed in the comprehensiveness and presentation of data in internally generated stand-alone reports, and in the use of data from externally generated reports. This variation reflects different objectives in presenting data. Summary presentations of a few performance indicators demonstrate quality reporting with a focus on providing assurance on compliance requirements. More comprehensive reports using a range of data and mechanisms to highlight performance variation and identify actions, reflect a quality improvement focus. This finding is echoed in the research of Jones et al (2017)

who found high performing boards use data for quality improvement, rather than assurance.

The need to identify variation, or areas for improvement, is fleetingly referred to in the healthcare governance literature (Kroch et al., 2006; Prybil et al., 2010). The use of specific mechanisms such as trending and benchmarking that support this process are examined in surveys (Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012) but relatively little attention has been paid to how well these mechanisms are used. The findings in Chapter 5 demonstrate little evidence of widespread use of benchmarking, allowing organisational comparisons to be made, regularly presented at the board or BQC. Where benchmarking information was available in external reports, data were often reproduced in board and BQC papers in terms of their relationship to the associated government target or their trends over time.

Cases did not always establish targets for quantitative healthcare measures to assist in identifying variation. When present, the origin and rationale for target setting was not often transparent. The contentious nature of organisational target setting is evident in this study. Views differed as to the value of setting aspirational targets, reflecting a 'do no harm' approach that often trigger red flags to which the board can became habituated, versus setting 'realistic' targets that acknowledge the inherent risk of acute healthcare delivery.

The problematic use of targets leading to triggering red flags for non-significant variation is identified in the literature (Anhøj & Hellesøe, 2017; Mountford & Wakefield, 2017). Challenges associated with target setting are reflected in the use of alternative methods of identifying variation at some cases. More highly engaged cases are found to supplement tables of quantitative data with detailed trend graphs for each indicator in a dashboard. Trends portrayed in graphs allow ready identification of patterns in data and are better at identifying variation for some indicators (Schmidtke et al., 2017).

Several other processes to identify performance variation, not addressed in the literature, were found in cases. A few cases used graphs to display disaggregated program level data to inform an understanding of variation between programs. Duckett et al (2018) highlight the usefulness of disaggregated data. These authors demonstrate

that complication rates vary by speciality and aggregated data can hide underperformance in specific program areas. A minority of cases used process control charts to distinguish between significant special cause variation and the normal variation or 'noise' in any process. Higher engaged cases also provided written commentary identifying variation with graphs and reports. A few cases developed sophisticated audit mechanisms to identify performance variation and system issues that informed action. These audit mechanisms move beyond familiar compliance and accreditation-related audit processes and represent comprehensive reviews of clinical programs through the comparison of existing care with internally defined standards of care.

Studies have stated the need to identify actions to address underperformance (Jiang et al., 2008; Baker et al., 2010), however little detail is provided as to how this is to be done. This study found that briefing papers for stand-alone reports and commentary associated with dashboard data are mechanisms used by some cases to ensure action is identified. A few more highly engaged cases demonstrated sophisticated review processes to determine whether actions have been effectively implemented, as seen in implementation reviews of recommendations arising from investigations of serious incident or audits.

The second healthcare governance task examined in this study was overseeing quality priorities. Descriptions of this task in healthcare literature have a focus on boards establishing strategic goals for quality (Joshi & Hines, 2006; Jiang et al., 2008; Baker et al., 2010; Jha & Epstein, 2010; Bismark et al., 2013; Pronovost et al., 2015; Mannion et al., 2016). Processes of cascading priorities throughout the organisation (Mannion et al., 2005a; Jiang et al., 2009) and monitoring strategic progress (Baker et al., 2010; Bismark et al., 2014) have received less attention in the healthcare governance literature.

Chapter 5 highlights that most cases signalled their engagement in the task of overseeing quality priorities through creating broad strategic directions or 'pillars' and associated broad subordinate priorities for improving the existing quality of care. However, there was little evidence of these priorities cascading down into subordinate planning mechanisms in any more than a symbolic way. Broad strategic quality priority headings were used as a catch-all for a range of operational or compliance activities in

subordinate plans. This is similar to the findings of Jiang et al (2009), who observed that the majority of boards in a survey of hospital board engagement did not mandate alignment on quality initiatives within the organisation.

It has been noted that specific quality priorities need to be measurable in order to gauge progress (Joshi & Hines, 2006; Baker et al., 2010; Pronovost et al., 2015; Mannion et al., 2016). The ability to assess progress with quality priorities at the corporate governance level was found to be limited by two main factors, in cases. Firstly, the general lack of specific measurable quality priorities, prevented measurement of progress. Secondly, the lack of transparent reporting on quality priorities at the board or BQC level. Reporting on progress was often through data and KPIs selected to broadly reflect strategic pillars rather than specific priorities.

This study demonstrates a lack of specific, measurable and transparent quality priorities, evident at the board or BQC, cascaded into operational plans to provide direction to senior staff and evaluated for progress. Cases demonstrated weak links to effective processes of overseeing planned strategic priorities, with a greater focus on emergent priorities arising from external requirements and to a lesser extent, internal imperatives. This finding reflects the research of Demb (1992) who found that boards are less involved in strategy oversight when organisations are more focussed on emergent priorities, than planned strategies. The absence of planned strategic quality priorities resulted in a lack of clarity regarding priorities for healthcare quality improvement expressed by interviewees. The importance of planned strategic priorities was confirmed in cases more by their absence. This finding is consistent with that of Jones et al (2017) who found that oversight of both planned and emergent strategies is a feature of higher performing boards.

When constructs influencing engagement were examined in Chapters 6 and 7, a number of additional taskwork processes became apparent. These governance processes, undertaken by leaders, influence how well the BQC meeting addresses its purpose and have received little attention in the literature. These processes are reflected in the addition of a governance taskwork category in the framework. This category describes processes of board and committee orientation (see Chapter 6, 6.3.3), agenda setting, reviewing data reporting, and governance effectiveness through

reviewing terms of reference and committee evaluations (see Chapter 7, 7.3.3). This finding is similar to that of Cornforth (2001) who, in a survey of UK charity boards, found that having the right skills, a clear understanding of roles and responsibilities, and board and management that periodically review how they work together, were key factors in explaining variance in board effectiveness.

Table 28 outlines key processes that support the achievement of each task addressed in this study. The processes in this table have been simplified from the more detailed explication of process outlined in Table 19 in Chapter 5 used to determine engagement scores.

Evaluating Healthcare Quality Taskwork Processes	**Overseeing Quality Priorities Taskwork Processes**	**Governance Taskwork Processes**
Processes of selecting healthcare quality data: • Board endorsed definition of healthcare quality exists that identifies measurable categories of quality • Conceptual categories used to structure quality reporting • Board and BQC calendar or schedule that identifies main quality reports and activities • Detailed board and BQC dashboard indicator framework • Periodic scheduled management and board review of reporting content	Strategic quality priority processes: • Strategic pillar/s addressing quality healthcare • Limited number of specific strategic priorities for improving quality healthcare	Governance processes: • Orientation and skill development • Agenda setting • Reviewing reporting framework • Reviewing governance effectiveness
Reporting processes: • Regular reporting at board and BQC • Dashboard/s indicators reflecting a range of dimensions of quality • Periodic standalone quality reports addressing clinical risks or quality systems • Periodic standalone quality reports addressing quality in program areas	Operationalising quality priorities: • Mechanism for cascading strategic priorities at governance level into subordinate plan • Subordinate governance plan incorporates quality initiatives from all sources (planned and emergent)	
Identifying performance variation processes: • Key quality indicators presented	Monitoring progress processes: • Measurable quality	

with analysis and action implemented, (including no action) • Quantitative data presented graphically with trends, agreed targets or acceptable limits or benchmark comparison • Data disaggregated to reflect program level, where possible • Internal and external reports provided with summary briefing document with background, analysis of data and issues and action • Periodic thematic analysis to identify causes of variation (e.g. incidents, patient feedback or experience) • Internal methods of performance assessment against evidence-based standards in areas of clinical risk • Periodic (e.g. annual) operational quality committee reports	strategies at a governance level • Regular reporting on progress with quality strategies at a governance level
Action identification processes: • Data analysis and system level action in response to all quantitative and qualitative data • Mechanism for tracking implementation and effectiveness of action that arise out of data review	

Table 28: Summary of taskwork processes

The findings chapters made clear that management staff play a key role in undertaking many of the processes that support effective governance. For example, senior quality staff, normally the BQC convenor, were found to work with the board member BQC chair to ensure agenda setting, orientation and reviews of committee and reporting frameworks occur. Similarly, effectively evaluating healthcare quality relies on careful management preparation of data and reports in consultation with board. This is consistent with both, emergent healthcare governance literature (discussed in Chapter 2) linking management quality activity to board activity (Weiner et al., 1996; Botje et al., 2014; Tsai et al., 2015), and calls for a broader view of participants in governance work than just board members in the governance literature (see for example Chait et al., 2005; Cornforth, 2012). Board members and managers interacting to carry out taskwork

is consistent with a stewardship view of governance, rather than an agency view. A stewardship view highlights, as does this thesis, the need for board members to have skills that add value to governance (Cornforth, 2003b). The collaborative working relationship, seen at some cases, reflects the interdependence of board members and senior management noted in not-for-profits in the literature (Harris, 1993; Chambers & Cornforth, 2010; Cornforth, 2012).

Evidence of co-production of governance does not preclude the agency approach. Aspects of agency are evident in boards' review of compliance and performance. As several researchers (Lewis, 2000; Sundaramurthy & Lewis, 2003) have identified, multiple modes of governance can operate concurrently, creating 'paradoxes, ambiguities and tensions'(Cornforth, 2003b, p. 11). The awareness of both the agency and stewardship role of boards was apparent among managers in cases. They identified the need for board members to be challenging and probing in their questions to management in order to drive performance, in line with an agency perspective. At the same time, managers expressed the need for board members to get more involved in processes of governance that managers largely drove, such as shaping agendas and reports or identifying quality priorities. This thesis highlights that board members are less aware than managers of the need for co-production of taskwork processes and the value of a stewardship approach. Most board members spoke more about holding managers to account than working with managers. Aspects of managerial hegemony were evident in the way that management largely undertook and directed many of the processes of governance.

Chapter 5 demonstrates that cases vary in their level of engagement in processes of healthcare quality. The next stage of this study addressed the gap in understanding why boards vary in their engagement in these processes. Chapters 6 and 7 examined constructs in the input and teamwork categories of the conceptual framework to address the second research question concerning what factors influence engagement. Key changes made to constructs in these categories are discussed in the following sections, with reference to the literature.

8.3 Reviewing inputs

Chapter 6 highlights the changes to inputs in the framework to reflect constructs found to influence governance engagement in this study. This section discusses the main changes which include; a refinement in understanding KSAs and governance composition, and the addition of constructs related to management hierarchy, geography, size and external evidence.

The literature describes technical KSAs as important for boards in healthcare quality governance in broad terms such as 'knowledge of quality and safety oversight' (Goeschel et al., 2011, p. 258) or 'expertise in quality of care' (Jha & Epstein, 2010, p. 184). This study confirms technical KSAs in areas of data analysis and quality improvement are important for both board members and managers, while identifying two additional KSAs: healthcare and governance. Healthcare KSAs are found to assist board members in understanding how hospitals work and were valued above clinical technical skills. Existing literature has previously identified the value of clinicians on boards (Jiang et al., 2009; Veronesi & Keasey, 2012; Veronesi et al., 2014; Tsai et al., 2015), but this finding progresses understanding of how clinicians add value to governance.

Governance KSAs are found to assist both in understanding governance responsibilities and tasks, and effective implementation of those tasks. Their absence in board member leadership positions are found to be a barrier to broader board engagement in healthcare quality processes. Governance KSAs overlap and encompass the notion of teamwork KSAs. Planning, coordinating tasks, communication and conflict management are important teamwork KSAs identified in the team literature (Stevens & Campion, 1994; Mickan & Rodger, 2005; Porter-O'Grady, 2015). This study found these KSAs, particularly communication skills, are important for both management and board. How to effectively question and challenge was a recurring theme raised by board members. Similarly, management skills in communicating logically and clearly are valued. Governance KSAs have not been addressed in detail in the healthcare governance literature to date. However, the findings in this thesis reflect the argument made by Vaughn et al (Vaughn et al., 2006) that healthcare boards and senior managers need teamwork training, including communication skills. This echoes a similar gap highlighted in related literature on the challenges of clinicians moving into managerial roles without necessary management KSAs (Loh et al., 2016).

This study broadens the focus on composition as a corporate governance level input influencing governance engagement to address BQC and management composition. The extant literature addresses board composition through examining executive versus non-executive members (Molinari et al., 1993) and clinicians on boards (Prybil, 2006; Veronesi et al., 2015). The issue of executive versus non-executive board members was not explored in the study as Victorian cases did not have executive board members and the two NSW cases with staff representatives on their board did not provide a sufficient evidence base from which to draw conclusions. Clinician board members are found to influence engagement positively through the expertise they can bring, if as discussed, sufficiently experienced in broader healthcare issues, rather than having a technical clinical focus. If present in sufficient numbers, this increases the likelihood of a clinical background board member in a board quality leadership position, either the board chair or the BQC chair. This was important as board chair or BQC chairs with healthcare skills were seen to contribute to an aligned leadership focus on quality in a few cases, which in turn influenced engagement.

The document review revealed relatively little focus on healthcare quality at the board level. The BQC was the site where most of the work of healthcare governance was undertaken. This is consistent with Jones et al (2017) who found that boards with a greater focus on quality improvement relied on their BQC for detailed scrutiny of healthcare quality. The BQC composition is found to be an important influence on engagement. The healthcare governance literature has typically examined whether a BQC exists (see for example Jiang et al., 2009; Bennington, 2010; Jha & Epstein, 2010), but there has been less focus on the committee composition, with the exception of (Jiang et al., 2009) who examined the involvement of physicians, CEO, and other executives in the BQC. As discussed in Chapter 5, no remarkable difference was found in categories of staff attending BQCs. Of more interest was the proportion of board members at the BQC. Cases with high proportions of executives and clinical staff were perceived and observed to inhibit engagement of board members in the BQC. More highly engaged cases demonstrate greater board member BQC exposure. This measure, reflecting board engagement in discussion of quality issues, is easily calculated, less ambiguous and less subject to bias than self-rated survey questions on board time spent on quality in the existing literature (see for example Vaughn et al., 2006; Jha & Epstein, 2010; Jha & Epstein, 2013).

In line with the scope of this thesis, encompassing both board members' and managers' roles in governance, the composition of the executive team interacting with the board was examined. Management hierarchy is found to be important. A clinical background CEO was linked to the creation of dedicated healthcare quality portfolios at the executive level. The need for skilled executives coordinating the organisation's healthcare quality improvement approaches, who can work across corporate areas such as finance and human resources, has been previously identified within the literature (Gautam, 2005). Having such a staff member on the executive team enables quality to be on the executive agenda. This, along with the perceived and observed healthcare quality focus of clinical background CEOs, leads to a strong focus on quality in these cases and is a key influence on engagement.

Geography and size are also added as organisational-level inputs to reflect their importance in influencing access to resources and skilled staff and board members. Organisational-level resources to support board and management skill development (Baker et al., 2010; Vaughn et al., 2014), production of data (Baker et al., 2010; Vaughn et al., 2018) and quality initiatives (Baker et al., 2010) have previously been identified as important. This thesis confirms organisational resourcing is an influence on engagement. Cases saw relatively more resources directed towards initiatives, quality improvement positions and skill development where there was a strong executive focus on quality. However, size and rurality are found to be important in determining resource availability. Rurality is a clear factor influencing the ability to recruit both suitable executive and skilled board members to undertake these tasks. Greater organisational size, often linked with geography, is also a key factor in the availability of resources, although the influence of geography and size on resources is mediated by the quality focus at the corporate governance level.

Evidence and data are constructs added to the external-level input category. This thesis finds evidence, in the form of recommendations arising from reviews of high-profile healthcare failures, is a strong influence on governance practices at cases. Inquiries resulted in specific recommendations on healthcare corporate governance practices which were eagerly debated and adopted at more highly engaged cases. This strong engagement with evidence reflects both the absence of practical guidelines regarding healthcare quality governance practice (as opposed to broader governance practices)

and the desire, consistently articulated by study participants, for greater understanding of healthcare quality governance practices. Chambers et al (2018), in an examination of changes to board practices after the Francis inquiry into failures at Mid-Staffordshire hospital, similarly found greater focus and engagement, if not always execution, in a range of practices related to improving healthcare quality. Jones et al (2017) also found that boards considered higher performing in quality improvement, proactively sought and engaged with evidence to inform understanding of best practice.

Evidence also acted indirectly to influence state-level support of hospital healthcare quality improvement. Both states saw increased investment in agencies to support data analysis, training and best practice initiatives after significant reviews of healthcare failings. While Victoria was in the process of developing this capacity following the failure at the Bacchus Marsh hospital, NSW interviewees frequently remarked on the useful data provided to them to inform a comparative analysis of healthcare quality. This was perceived to be particularly valuable in providing cases with state-level comparative data for healthcare quality evaluation. The literature touches on the value of suitable comparative data provided through external agencies to inform objective assessment of healthcare quality (Bismark et al., 2014). This thesis confirms this and highlights the importance of the broader role of external agencies in providing a variety of supports to strengthen healthcare quality oversight to health services in a devolved governance system. Providing access to training and best practice initiatives, along with data analysis, is seen as an important role for the state.

Sociocultural influences are rarely mentioned in the healthcare governance literature. A sociological viewpoint is helpful in appreciating the influence of 'multiple stakeholders, complex hierarchies and heterarchies, conflicting world views and politically-charged environments' (Waring et al., 2016, p. 2019) in healthcare. Sociocultural influences, while not explored in this thesis in sufficient depth to make definitive conclusions, were evident in this study. Participants expressed an awareness of others' place in organisational hierarchy, social status or expertise, which created perceived differentials in influence at the governance table. Medical professionals, for example, were perceived by non-clinical board members as having privileged knowledge. A striking feature of healthcare quality leadership is the prevalence of women in senior quality positions compared with board and executive makeup. The question of whether gender

influences the status and hierarchy of these positions is raised by this study and requires further investigation. The sociocultural construct is retained in the framework, but requires further examination in future research.

8.4 Reviewing governance teamwork

This section discusses the main changes made to constructs in the teamwork mediator category of the conceptual framework presented in Chapter 7. Changes include refining the understanding of communication and leadership and adding a reflexivity construct. These modifications are discussed with reference to the literature.

Communication is a dominant factor influencing engagement in healthcare governance evident at all cases. Governance is fundamentally concerned with creating cognitive outputs through communication of information, however there is surprisingly little detailed examination of communication in governance literature. This reflects a general neglect of board behavioural processes in governance literature (Erakovic & Overall, 2010). When communication is discussed in healthcare governance literature it is referred to broadly (see for example Vaughn et al., 2014; Mannion et al., 2015; Millar et al., 2015) . Healthcare governance research undertaken through cross-sectional surveys has a limited focus on examining whether quality data has been communicated via quality agenda items and dashboards. Less attention has been paid to verbal communication or how information is communicated in reports. Emerging research by Freeman et al (2016) examined board internal processes in a case study of four NHS boards and found differences in the framing of management reporting on infection control data, an aspect of communication. The findings of this thesis build on the detailed examination undertaken by Freeman et al, to highlight additional aspects of communication found to be important in influencing governance engagement. These include transparent logical management reporting, effective questioning and challenge and are described in this section.

A clear finding from this thesis is the value of a clear logical narrative in management reporting. Board members who have intermittent exposure to quality issues at meetings grapple to understand the large volume of complex information in meeting papers. The way in which information is conveyed is important in aiding their quick orientation to and understanding of issues. Verbal and written reports that are concise and use non-

technical language to present a logical narrative background to an issue, identify issues and current system-level actions foster board engagement. Reports formatted in this way promote either efficient noting of items where no further action is needed, or alternatively where issues are identified, direct discussion to analysis and implementation of action. The empirical governance literature is silent on this aspect of communication.

Effective questioning and board challenge are other important aspects of communication found to influence governance engagement in this thesis. Challenge has been identified by several authors (Millar et al., 2015; Freeman et al., 2016) and refers to the need for boards to remain 'restless' (Chambers et al., 2018, p. 188) in order to effectively interrogate quality issues. Management interviewees consistently expressed the desire for, and benefits of, effective challenge by the board. Effective challenge took the form of careful questioning of assumptions underlying data analysis and action taken. Simple questions such as 'why is this happening' and 'have these actions been effective' are often very effective in driving reflection and greater rigour of managers in approaching healthcare quality improvement. Effective questioning and board challenge also work to facilitate shared board understanding of issues. The way in which board members challenge, through the type of questions asked, has received little attention in the extant literature, but more coverage in the normative literature (see for example Machell, Gough, Naylor, Nath, & Steward, 2010; State of Victoria, 2017).

Open communication is found to be a fundamental influence on board engagement and has been identified previously in healthcare governance literature (Chambers, 2012; Millar et al., 2015). For boards to assess healthcare quality, managers need to present a realistic view of the current status of healthcare at the organisation. At a few cases explored in this study leaders actively promoted a sense of unease with the status of healthcare quality. Opportunities were created to remind board members of harm inherent in delivering healthcare through case studies of serious incidents, walkarounds and discussion of emerging clinical risks. This leadership approach establishes a sense of constant vigilance at the governance level and promotes open discussion and analysis of issues. Promoting this sense of vigilance is similar to the concept of 'restlessness' proposed by Chambers et al (2018).

Framing communication, the process of developing a particular perspective on an issue (Chong & Druckman, 2007), was observed in cases to either highlight issues that needed attention (see Box 1: C1) or in casting doubt on the reliability of methods used to generate data (see Box 2: C8). Framing was found to be an important aspect of communication influencing engagement in governance practices. This has been identified in emerging literature (Freeman et al., 2016). Jones et al, found boards lower performing in quality improvement were more likely to put a 'positive spin' (Jones et al., 2017, p. 984) on poor performance.

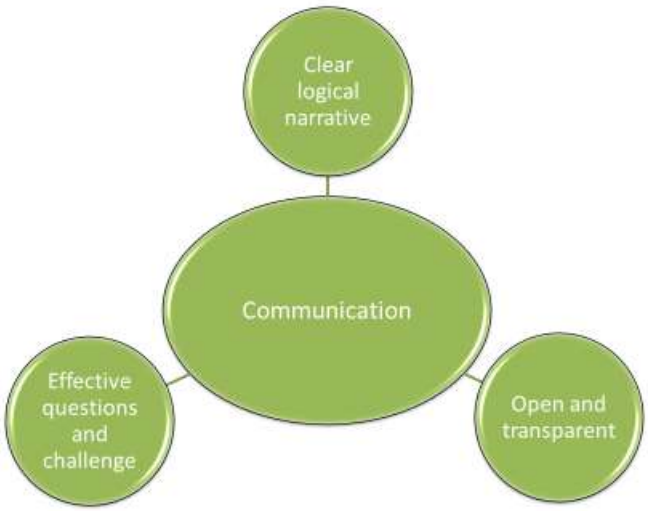

Figure 12: Elements of communication influential in healthcare governance

The healthcare governance literature, while frequently mentioning the importance of leadership, rarely explores the components of leadership beyond the need for leading a quality focus (see for example Vaughn et al., 2006; Jiang et al., 2012; Millar et al., 2013; Millar et al., 2015). Chapter 7 finds important leadership elements included a focus on healthcare excellence and quality improvement, stable and aligned leadership, and effective meeting leadership and are discussed below.

The need to develop a clear sense of direction is consistent with the leadership literature (James, 2011). However, this thesis finds there are three possible quality foci taken in cases; meeting healthcare quality compliance requirements, developing quality system maturity or organisational healthcare excellence. To some extent, these foci reflect different stages of maturity of organisations, however they also reflect an understanding of governance purpose. The thesis demonstrates that more highly engaged cases have a clear organisational focus on achieving healthcare quality excellence and this is associated with a culture of quality improvement that fosters open discussion of quality issues and often innovative internal initiatives to assess, understand and improve quality healthcare A leadership focus on excellence also saw the extensive use of external data and evidence. This focus on excellence is also found to be a feature of boards higher performing in quality improvement in research undertaken by Jones et al (2017).

Leaders' influence on engagement in healthcare quality tasks is more evident when the leadership foci of key players are aligned at the governance level. When a CEO, quality executive and board chair share the same healthcare quality focus, this is seen to strongly influence governance engagement. These cases also show stability in CEO and/or board chair, quality executive positions that allow institutional knowledge and focus to be retained. This finding is consistent with those of Baker (2011); who found higher performing organisations are characterised by low turnover of senior leaders and smooth leadership succession planning.

Stable, aligned leadership that creates a shared focus on quality and promotes engagement in a range of healthcare governance processes is in line with a 'post-heroic model of leadership' (The Kings Fund, 2011, p. 19). The heroic model describes an organisation transformed by an individual leader (Vroom & Jago, 2007). In contrast, the post-heroic model is not derived from the individual attributes of a single leader but from adaptive, distributed and shared leadership. This form of leadership utilises collective influence, wisdom and skills to engage in new practices that will assist the organisation (James, 2011). Leadership takes place through changing existing organisational approaches and introducing 'new practices and innovations' (James, 2011, p. 5).

The final key aspect of leadership emerging from the research comprising this thesis is effective meeting leadership. Effective leadership of BQC meetings is found to be critical in fostering engagement in healthcare quality governance tasks. A chair's role, supported by a management convenor, in ensuring meeting time is used efficiently to encourage discussion and reflection, and in influencing information provision is vital in ensuring BQC meetings accomplish their purpose. Selecting a BQC chair is often influenced by the desire to have a chair with a clinical background. However, it is clear from cases that a lack of leaders with governance KSAs in understanding governance tasks, planning, coordinating and communicating, is a clear impediment to effective meetings. This finding reflects related research of Harrison and Murray (2012) in examining board chair leadership. These authors found that exceptional chairs were characterised by the 'capacity to lead' (Harrison & Murray, 2012, p. 427), which meant understanding their role, having the ability to clarify issues and collaborate, and be organised.

Figure 13: Elements of leadership influential in healthcare governance

Reflexivity is the one addition made to constructs in the governance teamwork category. Reflexivity has been defined as the extent to which participants reflect upon

the group objectives, strategies and processes and then plan for action to adapt to current needs (Widmer, Schippers, & West, 2009). Reflexivity is only sparingly referred to in healthcare governance literature (see for example (Dixon-Woods et al., 2013). Reflexivity operates in two main ways in cases; through processes that promote greater interrogation of quality data, issues and actions, and through processes of reviewing and reflecting on governance effectiveness. In the former type, the benefits of reflexivity are experienced by management when subject to effective board questioning and challenge and when required to write clear logical reports. The process of articulating the background, analysis and rationale for and impact of actions creates an opportunity for managers to reflect on issues and initiatives that is not normally afforded to them in the conduct of their everyday work. The latter type of reflexivity, reviewing governance effectiveness, is more in line with emerging research in team literature highlighting the value of reflecting on how well a team is meeting objectives, making adjustments as needed and innovating (Schippers, West, & Dawson, 2015). Kay and Goldspink (2015) have also identified the value of reflection, prompted by the board, in a study of 100 chairs of Australian organisations.

Decision-making, while rarely observed in the cases, is retained in the category of behavioural processes as decision-making is potentially important. Decisions in cases were largely made ahead of governance meetings and often relied on the technical knowledge of clinicians and managers, as in the case of deciding on actions to address underperformance or identify quality priorities. This finding reflects Abbotts (2008) finding in a study of boards of UK primary care trusts that decision-making was not a prominent part of board meetings. Opportunities for overt corporate governance decision-making lay more within the board's role of strategy oversight. I was not privy to discussions regarding the development of strategic priorities, however there was little evidence of the development of specific strategic quality priorities and therefore little decision-making in this area. The creation of specific quality priorities that are overseen at a corporate governance level is an area for development in hospitals and will, when undertaken, require effective decision-making. The decision-making construct is retained in the framework as a theoretical construct for future examination, when the area of governance oversight of healthcare quality strategy is more mature.

8.5 Reviewing governance effectiveness

This study aims to identify characteristics of effective governance of healthcare quality. Implicit within this aim is the ability to determine governance effectiveness. Effectiveness corresponds to the output category of constructs in the conceptual framework. Three levels of governance outputs were proposed, at the individual, board and organisational level, in the conceptual framework. Studies of governance effectiveness have largely used measures of organisational-level financial performance (see for example Bradshaw, Murray, & Wolpin, 1992; Dalton et al., 1998; Ostrower & Stone, 2006). Governance research, in the area of healthcare quality, has often used organisation-level measures of healthcare processes and/or outcomes (see for example Jiang et al., 2009; Jha & Epstein, 2010).

The initial intention of this study was to identify characteristics of effective governance of healthcare quality through comparing cases with different levels of performance in a range of organisational level healthcare quality measures. This approach was abandoned due to a lack of suitable measures of organisational healthcare quality performance as discussed in Chapter 4 (see 4.1.3). Development of state and national measures of hospital healthcare quality that are robust and comparable is nascent in Australia. The Australian Government Productivity Commission review into data use identified that Australia falls short in respect to healthcare and hospital data when compared to other comparable nations (Productivity Commission, 2017). This report also finds the Australian public sector exhibits 'a reluctance to share or release data' (Productivity Commission, 2017, p. 34). This reflects the experience in this research, with the reluctance of the Victorian Department of Health to release outcome data. Duckett et al, argue that useful data could be generated for comparative purposes, but existing datasets needs to be more 'accurate, relevant, accessible and understandable' (Duckett et al., 2017, p. 3). The lack of data represents a significant barrier to understanding healthcare quality and evaluating improvement strategies at a national, state and organisation level in Australia.

The challenge experienced in finding suitable organisational-level quality healthcare measures, in this study, was also a frequent concern raised by interviewees within cases. Comparative data is essential in informing a clear understanding of an organisation's performance. Bismark et al (2013) found in their survey of 233 board members in

Victoria, Australia, that almost all respondents believed the overall quality of care delivered by their organisation was the same or better than the typical Victorian health service. The authors indicate this overoptimistic response highlights the paucity of data available to inform an objective understanding of an organisation's comparative status in relation to healthcare quality.

Board overoptimism on organisational healthcare performance is compounded by a tendency, seen in this study, for governance reporting to gravitate towards the use of data generated for compliance purposes. Data generated for assessing performance at the funder level is generally data that is more easily collected, measured, benchmarked and trended. However, these compliance measures are not necessarily satisfactory measures of healthcare quality. For example, much of the Australian performance data on the safety dimension of quality is provided through measures that are focussed on complications that occur at low frequency, such as *Staphylococcus aureus bacteraemia* infections (Duckett et al., 2018). These measures, occurring at a low frequency, provide little ability to discriminate between health services or detect changes over time.

The lack of organisational-level healthcare quality performance measures in Australia required a rethink of the approach to determining governance effectiveness in this study. Team literature, reviewed as part of developing the conceptual framework, provides valuable insights into alternative conceptualisations of effectiveness. A well-developed team effectiveness model, used as the basis for the development of the conceptual framework in this study, presented three levels at which to view team effectiveness; individual, team and organisational level (Mathieu et al., 2008). This IMOI model highlights the opportunity to assess governance effectiveness at the level of the team, or in the study context, the participants at the board table. The healthcare governance literature demonstrates a positive association between board engagement in healthcare quality governance processes and measures of organisational healthcare quality. Engagement in governance activities, therefore, became the lens through which governance effectiveness is viewed in this thesis. This approach to assessing governance effectiveness is in line with emerging research. Jones et al developed a measure of healthcare quality governance effectiveness, presented as a 'quality improvement maturity rating' (Jones et al., 2017, p. 980) based on board activities to compare 15 healthcare organisations. Bismark et al (2013) undertook a similar inventory of

engagement in board-level activities. Both these studies measure governance engagement based on processes previously identified in the literature. This thesis has revisited governance processes, in light of empirical evidence, to provide an expanded view of governance processes from which engagement is understood.

In this thesis, governance effectiveness is indicated broadly through categorising cases as high or low engagement through analysing their engagement in processes related to two key tasks of healthcare quality governance. Governance engagement in healthcare quality processes is a more proximal indicator of governance effectiveness than organisational-level measures. Proximal indicators of governance effectiveness are less likely to be influenced by confounding factors. Organisational measures of quality healthcare can be confounded by factors external to the board table, such as workforce issues and patient demographics.

Barriers to obtaining organisational-level measures of quality performance in countries such as Australia, combined with their more distant link to governance, highlight the benefit to both researchers and governing bodies in exploring more proximal indicators of governance effectiveness. The process used to generate engagement levels in this study requires further refinement and testing to produce a valid and reliable tool to measure taskwork engagement. Similarly, a measure of governance teamwork, addressing behavioural and emergent states could be developed through amending existing teamwork tools as outlined in Chapter 3 (see 3.5.3). Evaluating governance effectiveness through assessing corporate governance-level outputs could be combined with available organisational quality measures or individual-level outputs, such as director and management effectiveness, to provide a more comprehensive view of governance effectiveness. As such, the corporate governance level output measures remain in the framework as theoretically derived constructs requiring further research.

8.6 Healthcare Governance Performance Framework

The conceptual framework, initially developed to guide data collection and analysis, is revisited in this section. A revised framework is outlined and describes constructs, revised on the basis of empirical work conducted for this thesis, found to influence governance engagement. The revised framework, The Healthcare Governance Performance Framework (HGPF), is presented in Figure 14

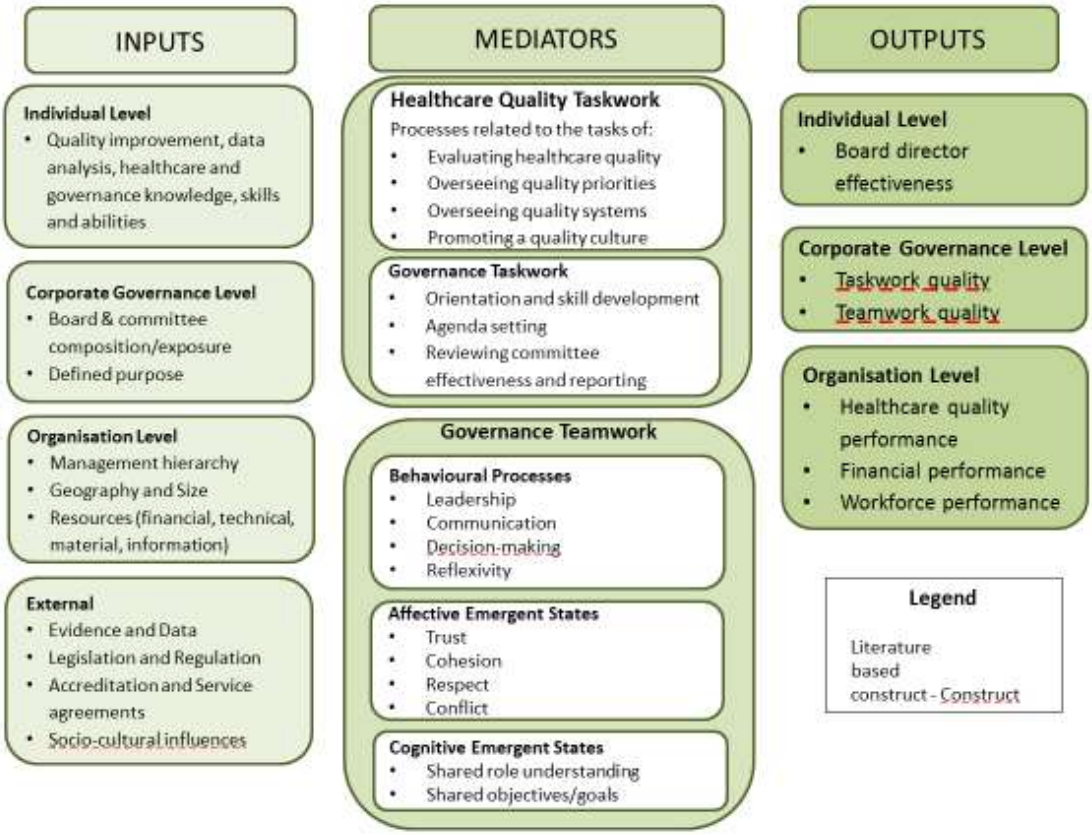

Figure 14: The Healthcare Governance Performance Framework

The HGPF makes visible input, taskwork and teamwork mediators influencing governance effectiveness. This is the first time that these constructs, some of which have received little attention in the literature, are brought together in a framework. The framework promotes an understanding of the complexities of governance and helps highlight why board members and managers sometimes struggle to engage with healthcare governance tasks. The framework does not visually depict the interactions between constructs as these are complex and unique to each organisation and are discussed in the next sections.

8.7 Interacting constructs

Complex interactions of input and mediating factors are found to influence governance engagement in healthcare quality processes in this study. This section highlights these

interactions by focussing on two key constructs influencing engagement: communication and leadership. Communication and leadership are found to influence each other and in turn are influenced by a range of input and other mediating teamwork constructs.

8.7.1 Influences on communication

Communication is influenced by leadership and a range of other constructs that are outlined in this section. Effective BQC meeting leadership is a key factor found to promote effective communication. The governance taskwork of chairs and staff in orientating new board members, developing agendas, reviewing reporting and evaluating committee effectiveness support clear logical reporting and efficient use of time to allow effective communication at meetings. Chairs that facilitate meetings to allow sufficient time for discussion of important items were clearly distinguishable from those who preside over a one-way passive delivery of information from management or alternatively allow prolonged discussion of tangential areas. Leaders that promote a quality improvement culture, within cases, foster open communication of healthcare issues. Leaders at more highly engaged cases also create opportunities for discussion of healthcare quality through ensuring BQC composition and structure enable greater board member exposure.

Trust, an affective emergent state, is found to be an integral part of open communication. Existing literature from studies undertaken in England, where NHS boards are comprised of non-executive and executive members, has focused on board members trusting each other (Chambers et al., 2013; Millar et al., 2015). The need for trust between boards and senior executives in promoting effective working relationships, more relevant in the Australian context, has previously been noted in the literature (see for example Baker et al., 2010; Buechner et al., 2014; Szekendi et al., 2015). Trust was evident in cases where management felt able to communicate openly 'warts and all' (IP4, BQC chair, C1). This finding reflects the understanding of trust as providing participative safety that allows managers to share information and communicate openly (Peralta, Lopes, Gilson, Lourenco, & Pais, 2015).

Trust and respect are found to be closely linked in fostering communication. Respect is often raised in healthcare literature but applied more to the conduct of staff to patients

and managers to staff (see for example Dixon-Woods et al., 2013). While the need for boards to conduct their work in an 'atmosphere of respect' (Baker et al., 2010, p. 3) has been identified, there has been little exploration of this construct. The benefits of mutual respect are apparent in this study. Management respect for board members was found to foster board challenge. In the same way that managers need a safe environment to communicate openly about the status of quality, board members need to feel they are respected to trust that their questions and challenge are welcomed and encouraged. Respect for board members was evident where management appreciated the skills the board brought to governance. A few CEOs actively promoted management respect for board members through making clear expectations of a respectful relationship, highlighting the role and value of the board and creating opportunities for board engagement with management and staff. This finding is consistent with research undertaken by Herman and Heimovics (2005), which found that demonstrating respect towards board members was a key characteristic of effective CEOs.

Respectful board questioning of senior management also influences effective communication. Managers welcomed questions from board members that acknowledged their expertise and work undertaken. Questions framed with the intention of drawing on management skills and experience to explore and extend their analysis of issues and approach to improvement were valuable. There is evidence that persistent but respectful board challenge in pursuing greater understandings of healthcare quality issues, over often extensive time periods, drove effective change at cases explored in this thesis. This finding is consistent with emerging literature identifying the need for respectful challenge (Kay & Goldspink, 2015). It is also similar to the finding of Chambers et al (2018) that board support of executive was equally important as challenge. Freeman et al, further noted respectful challenge at one NHS board enabled depersonalised exploration of issues and improvements (Freeman et al., 2016).

Cohesion and conflict, affective emergent state constructs, are also found to influence communication. These constructs, while rarely mentioned in the healthcare governance literature, are important constructs in the governance and team literatures. A 'healthy tension' (IP11, CEO, C3) was found to be the preferred dynamic between boards and managers. That level of tension exists when both management and board members

understand their role, acknowledge the value of governance and both parties undertake their respective governance tasks with rigour. A healthy tension reflects optimal levels of conflict and cohesion. The interrelationship between conflict and cohesion has been widely noted in the literature on teams (Tekleab, Quigley, & Tesluk, 2009). Overt conflict, when evident in a case, negatively influences communication. Lack of tension, where board members asked few questions, was also counterproductive. This study finds that while conflict needs to be low, some tension needs to be present in the form of board challenge.

Cohesion is found to be optimal when near a midpoint on a continuum from high social engagement to little cohesion. For example, at C8, there was an absence of healthy tension and an overly casual atmosphere at the committee which hindered effective challenge at the governance level. The presence of mutual trust and respect along with a healthy level of tension is found to be more conducive to open communication by managers and respectful challenge by board members.

Shared role understanding, a cognitive emergent state, is also found to influence the approach taken to communication. Shared understanding of the purpose and objectives of governing healthcare quality is a key factor in the appropriate structuring of the BQC meeting composition, agenda and discussion. Cases demonstrating a lack of shared understanding of the purpose and objectives of governing healthcare quality, were characterised by either more operational discussion (e.g. C7N, C8) or one-way communication of information by management (e.g. C6) at the BQC. Shared understanding reflects inputs such as the degree to which a clear purpose and roles are expressed in TOR and broader policy guidelines, and the presence of governance KSAs.

8.7.2 Influences on leadership

The preceding section highlights the interaction of constructs influencing communication. Healthcare governance leadership is similarly influenced by multiple input and mediating factors. CEOs and quality executive staff with knowledge and experience in healthcare quality and understanding of quality improvement foster a focus on healthcare excellence. They understand the need to drive a focus on healthcare excellence through internal activities, rather than relying on compliance activities. The leadership provided by senior quality staff is influenced by their seniority and skills. In

Victorian cases, a clinical background CEO was found to elevate the position of the quality staffer to an executive position. Governance KSAs enable effective BQC chair leadership in understanding and controlling the level of detail provided in reports and in discussions of healthcare quality to promote meeting effectiveness. When strong executive healthcare quality leadership is combined with a board chair skilled in governance and healthcare, a shared understanding of objectives results in effective and aligned leadership. Organisational factors such as size and geography influence the ability to obtain both skilled board members and executive staff to ensure effective leadership.

Where role understanding and skills in quality improvement and governance are less widely developed and aligned in key leaders, it is evident that more powerful members of the BQC can influence the direction of proceedings. This is seen at three cases, via the chair, the CEO and the director of medical services (at C6,7,8 respectively) dominating proceedings and changing the focus of the meeting, in the latter two cases to a more operational focus and in the former to a more punitive focus.

The effective use of evidence is closely linked to effective leadership. More highly engaged cases are characterised by leaders proactively engaging with findings from inquiries into high-profile reviews of healthcare failures. Evidence from these cases is a powerful force for reflection and evaluation of governance and healthcare quality taskwork processes when combined with curious leadership.

The influence of external contextual factors on leadership composition and focus was apparent in the comparison between Victorian and NSW cases. In NSW, a mandated requirement for a clinical governance unit with a director of quality ensured a focus on healthcare quality at the executive table. The influence of historical practice was also evident in the state comparison. In NSW, regulations required the development of a LHN BQC. However, the BQC at both cases was the only dedicated forum created for centralised discussion of quality healthcare issues affecting hospitals within the LHN. This, combined with a history of advisory councils with little involvement in healthcare quality, led to the NSW BQCs having strong elements of operational management as opposed to governance oversight. History and regulatory requirement influenced the understanding of the purpose and opportunities for leadership at a governance level.

Summaries of the BQC meetings observed at C1 and 8, drawing on the vignettes in Box 1 and 2 (see Chapter 7), are provided in Table 29. These summaries highlight key characteristics of communication and leadership at the two cases. Table 29 also documents and compares the influence of multiple constructs on leadership and communication.

	Case 1	Case 8
Summary of communication and leadership at BQC meeting observed	Effective leadership and communication: • 16 participants for 105 minutes • Focus on key clinical risks and system issues • Open communication and framing to highlight risk • Reports assumed read • Time made for questions • Chair summarised discussion and action	Ineffective leadership and communication: • 12 participants (not quality manager) for 50 minutes • Half meeting on detailed clinical management • Framing quality issues as problems with data collection • Questions mainly from one board member • Chair did not direct discussion to identify issues or actions
Inputs - KSAs	• Skilled board & executive • CEO clinical background • BQC chair with well-developed governance and healthcare KSAs	• Underdeveloped KSAs in board and executive • Finance background CEO • BQC chair with limited governance/healthcare KSAs
Inputs - Composition	• BQC exposure 32 hours/year	• BQC exposure 18 hours/year
Inputs - Purpose	• Clear purpose for BQC in TOR	• Clear purpose for BQC in TOR
Inputs - Hierarchy	• Executive quality position	• Quality manager position
Inputs - Resources	• Well-resourced quality directorate	• Limited resources and quality staff
Inputs - Geography & size	• Large metropolitan service	• Small rural service
Inputs - Evidence	• Active engagement with evidence	• Reactive engagement with evidence via departmental requirements
Inputs – Service agreement and accreditation	• Meeting accreditation and service agreement balanced with internal drive for healthcare excellence	• Service agreement and accreditation largely drove quality healthcare activity
Inputs - Legislation	• Clear legislative board and BQC responsibilities for large health services	• Unclear legislative board and BQC responsibilities for small health services
Behavioural process - Leadership	• Stable executive and board • Leadership focus on healthcare excellence and quality improvement	• High executive turnover • Leadership focus on finance and accreditation
Behavioural process -Reflexivity	• Robust respectful challenge • Regular review of reporting and committee effectiveness	• Little challenge • No review of committee or reporting
Affective emergent state - Trust/respect	• Mutual trust and respect	• Trust and respect less obvious or expressed
Affective emergent state -	• Healthy tension	• Casual relaxed atmosphere

Conflict/Cohesion		
Cognitive emergent state - Shared understanding	• Shared purpose and task understanding	• Lack of shared understanding of purpose and tasks

Table 29: Comparison of constructs influencing communication and leadership

This section clearly demonstrates that constructs influencing governance engagement in healthcare quality tasks do not work in isolation, but show multiple interactions with each other. The complexity of interacting factors influencing engagement highlights that simple linear relationships between constructs and measures of governance effectiveness do not adequately represent the reality of governance.

8.8 Complexity

It is evident, from the analysis, that cases have unique combinations of factors influencing engagement. These unique patterns of constructs influencing engagement reflect the organisational and contextual characteristics of each case. This is highlighted through examining the two least engaged cases. At C7N, a lack of clear purpose for the BQC, board members greatly outnumbered by executive and clinical staff at the BQC, and a history in NSW of more operational and management-driven approaches to governing healthcare quality, contributed to lower levels of governance engagement. At C8, a lack of board skills in healthcare and governance, a non-clinical CEO with an organisational hierarchy where quality was removed from the executive table, a lack of time allocated to the BQC, lack of aligned quality leadership and the recent transition of a BQC from a more operational committee, all contributed to lower engagement.

Similarly, unique patterns were observed at highly engaged cases. C1 and C3 were characterised by strongly aligned leadership, clinical background CEOs, mutual trust and respect, and a clear culture of excellence in healthcare. C4 and C2N were characterised by innovative processes on internal assessment of quality, financial background CEOs and strong engagement with evidence.

Making transparent the unique, but changeable set, of interacting factors influencing governance engagement at each organisation is useful in highlighting the need for constant reflection and re-evaluation of governance effectiveness. Governance reviews

can highlight the current factors influencing engagement and enable appropriate responses to be developed.

8.9 Characteristics of effective governance of healthcare quality

Most extant literature paints a picture of highly engaged boards largely in terms of a few input characteristics (e.g. presence of a BQC or clinicians on the board) and a restricted number of internal board processes (review of dashboards, a quality agenda item and regular review of data). This chapter demonstrates that these few characteristics do not adequately differentiate levels of governance engagement at Australian public hospitals. Through examining governance tasks and processes in greater depth, a more complete picture of a highly engaged board has been developed. When combined with input and mediating constructs found to consistently influence engagement, the characteristics of effective governance emerge. These characteristics represent an idealised highly engaged board and management team working on corporate governance tasks. In practice, not all these characteristics were noted in all more highly engaged cases. The characteristics of effective governance of healthcare quality can be described as:

- Board members and management with governance, healthcare and improvement skills that inform an understanding of governance responsibilities and tasks and healthcare quality improvement approaches
- Governance composition and leadership processes that promotes adequate time for open safe discussion, respectful challenge and reflection on effectiveness
- Logical, clear reporting to provide a comprehensive overview of specific areas of risk across the organisation and within program areas, and identify system-level action
- Aligned, shared and distributed leadership focus on healthcare excellence that drives internal initiatives to explore and resolve healthcare underperformance
- Effective use of external evidence and support to drive improvement in governance and healthcare improvement.

These characteristics can be summarised further. Chambers et al (2013), proposed a triad of high support, high challenge and high engagement as summary characteristics of effective boards. Based on the findings in this study, a similar summary

characterisation is made. However, it differs in content due to the scope of this study, addressing both board and mangers as participants in corporate governance, and as a result of the findings of this study. The characteristics of effective corporate governance of healthcare quality can be described as the quartet of engaged, focussed, vigilant and reflective.

The benefits of 'engagement' in tasks and processes of healthcare quality governance is assumed in this study and supported by the literature to date. Highly engaged cases are characterised by a clear aligned 'focus' on both the purpose of governing healthcare quality in driving healthcare excellence, and the tasks and processes required to achieve this.

More highly engaged cases are characterised by a sense of constant 'vigilance' in examining the quality of healthcare. This approach to governance acknowledges that the healthcare setting is a complex high-risk environment. This vigilance is expressed through a thoughtful comprehensive approach to data selection to inform the task of evaluating healthcare quality. These cases move beyond using data generated for compliance purposes, to identify a range of qualitative and quantitative data that inform governance. This includes the development of internal mechanisms to investigate specific areas of significant clinical risk to identify underperformance and areas for improvement.

More highly engaged cases create opportunities for 'reflection' in their approach to governing and improving healthcare quality. This reflexivity is evident through respectful challenge, regular reviews of governance and committee processes, reviews of reporting, and careful consideration and exploration of governance research and evidence.

8.10 Limitations

The research approach and design used in this study brings with it a unique set of benefits and limitations. The benefits of a comparative case study design have been demonstrated in the level of detail with which an examination of healthcare quality governance work has been undertaken and the way in which factors influencing engagement have been illuminated through comparing cases and states. Limitations

inherent in using a comparative case study include issues of generalisability, along with practical limitations experienced with data collection in this study and are discussed in this section.

The findings of this study are derived from an examination of corporate governance occurring in public sector acute hospitals in Australia, specifically Victoria and NSW. The conduct of corporate governance cannot be separated from the organisations within which boards are situated, nor the broader external influences acting on organisations and boards. Generalisability of theory generated from the findings, as represented by the HGPF, therefore is limited to this context.

The literature used to identify constructs for inclusion in the HGPF is derived largely from the US and UK and an argument is made that the framework is useful more broadly for structuring future healthcare governance research in other countries. However, the findings arising from application of the HGPF in other countries is likely to highlight different ways in which constructs operate in these settings due to contextual factors. The theory as embodied in the conceptual framework, as with any theory, needs to be tested in new contexts (Yin, 2009).

Theory generated from the study findings are generalisable only to the acute sector from which both the literature and evidence was derived. Purposive selection of cases was undertaken to ensure a range of cases from different geographical locations were selected in each state and, in the case of Victorian cases, different size organisations to broaden the applicability of theory to a wide range of organisations falling in to the acute public hospital setting. The applicability of the findings to other healthcare settings such as primary care would need to be tested.

Several limitations arise in relation to data collection methods used in this study. The first is the number of cases studied in NSW. A third case would have been preferable to provide a stronger evidence base from which to draw conclusions about contextual factors. The detailed examination of two cases strongly suggests differences in state-level influences, however a third case would have strengthened this further. The second limitation is in the observation of one BQC committee meeting. A single BQC meeting may not be representative of all BQC meetings and may reflect an aberrant event due to

researcher observation or other circumstances. In this study greater certainty about observations was gained through alignment of interviewees' perceptions of meetings with researcher observations. In addition, the standardised structure of the BQC meetings make it unlikely that the meetings observed deviated greatly from normal.

The scope of data collection was limited to two of four key tasks of healthcare quality governance identified from the literature. This was due to practical constraints on data collection and analysis time and the relative importance and ease of data collection for the two tasks chosen. Data collection in relation to the out-of-scope task of promoting organisational leadership and culture would have required a much broader scope of inquiry to understand organisational culture. Similarly, exploring the task of quality system oversight may have been very time consuming given organisations differ in the directorates and committees established to oversee key quality systems. The two tasks selected reflect not only important tasks, but tasks in which data collection could be limited to the board and BQC.

8.11 Contributions to research

This study aimed to identify characteristics of effective governance of healthcare quality in Australian public hospitals. It addresses the aim through testing and refining a conceptual framework developed from a large body of literature in the fields of governance and team theory and emerging research in healthcare governance literature.

This study addresses a gap in understanding the internal processes of healthcare boards to answer the research question of how boards and managers undertake this work. The research approach using multiple data collection methods has enabled a thorough examination of board practices and insight into the 'dynamic and messy lived reality of board governance practices' (Freeman et al., 2016, p. 16). Document reviews, interviews and observation undertaken in each case provided triangulated evidence of an extensive range of processes required to effectively govern healthcare quality. Data collection and analysis, while labour intensive and prolonged, has provided a more comprehensive picture of practices than has been previously presented in this field.

The second main study contribution is in addressing the research question of what influences engagement, through identifying a range of input and mediating factors influencing engagement in tasks and processes of healthcare quality governance. Previous research in the healthcare setting has a focus on compositional influences and more recently on limited aspects of the working relationship between boards and managers. This study has undertaken a comprehensive investigation of a wide range of factors influencing healthcare governance engagement. The act of governance is not a simple relationship between inputs and outputs, or even a simple linear input – mediator - output relationship. This study highlights a multitude of factors that interact with each other in unique combinations in each organisation to shape governance engagement.

The third main contribution of this study is the development of the HGPF. A conceptual framework was initially developed to guide the exploration of governance processes and influences on engagement. The framework was generated through a process of mapping commonalities between governance and team effectiveness literature. This mapping suggested a number of constructs from the team literature were applicable to, but not yet fully explored in, the governance context. The resulting framework encompassed both literatures and outlined taskwork, input and mediating constructs influencing governance effectiveness. The framework was used to guide the collection and analysis of data in this study to address the research questions. Through analysing empirical findings constructs in the framework were modified to develop the HGPF.

The HGPF outlines a comprehensive range of factors found to influence the effective governance of healthcare quality in the Australian public hospital setting. There is currently no other framework that brings together the findings from emerging literature in this area and incorporates constructs from a related field to provide a comprehensive articulation of key influences on healthcare quality governance. The framework, with a few modifications, has proved valuable in understanding and exploring governance in the Australian public hospital context. The HGPF provides a sound basis for undertaking theory-led research in healthcare governance.

Finally, this thesis adds to the limited literature on healthcare governance in the Australian context. Ultimately, this study contributes to a deeper understanding of the influences on the work of boards and managers in governing healthcare quality.

8.12 Principles of governance engagement

There is a relative dearth of literature that outlines underlying principles that support effective governance of healthcare quality. Principles outline the basic elements of theory, In this research study, the principles outline the key influences on healthcare governance as identified in the HGPF. Principles are more useful than narrow prescriptive descriptions of governance structures and processes as they promote understanding of the objectives in governing healthcare quality. To address this gap a set of principles for governing healthcare quality have been developed. These principles highlight both fundamental principles that all health services need to consider, as well as aspirational principles that more mature governing bodies may find helpful in further strengthening healthcare quality governance.

The development of principles, focused on activities at the organisation, carries with it the risk of limiting governance participants' attention on internal controllable influences at the expense of important external and contextual influences that are outside the control of organisations. However, in practice, organisations can only, in the short term, influence factors that they can directly control.

Area	Principle
Healthcare care and quality improvement skills	Fundamental Principle: • All board members knowledge in healthcare, quality improvement and data skills is assessed. A capability framework for governing healthcare quality addresses skill development through mechanisms of orientation, committee exposure to quality healthcare discussion and ongoing education is developed. • All quality staff have quality improvement and data skills Aspirational Principle: • Boards contain more than one member with skills and experience in understanding healthcare organisations and how quality improvement is applied • The executive management team contains an executive skilled and responsible for healthcare quality
Governance skills	Fundamental Principle: • All board members' knowledge of the specific responsibilities and objectives of healthcare quality governance is assessed. A capability framework is developed as described above • Board members undertaking chair roles have governance and leadership

	skills assessed and capabilities addressed • All staff interacting with board members have fundamental understanding of governance roles and reporting needs Aspirational Principle: • Board and BQC chairs skilled and experienced in governance • Executive staff skilled in governance
Board Quality Committee structure	Fundamental Principle: • BQC membership reflects skills in healthcare, data analysis, quality improvement and governance processes through board members and co-opted members • BQC membership includes those with clinical and non-clinical backgrounds • TOR include: ➢ Clear identification of BQC purpose, responsibilities and related tasks ➢ Clear identification of processes related to each task ➢ Process for endorsement/review of data or reporting calendar to meet committee responsibilities ➢ Process for review of committee and TOR ➢ Process for reporting back to board Aspirational Principle: • Board member exposure to BQC is maximised • BQC chaired by board member with governance & healthcare experience
Communication	Fundamental principles: • Data reported addresses basic information requirements of background, data analysis, issue identification, action taken, action evaluation • Effective board challenge through focus on identifying significant healthcare performance variation and how effectively variation is resolved Aspirational Principle: • Boards and managers work collaboratively to identify and understand issues with healthcare quality and quality priorities • Respectful open communication acknowledges the skills and experience of managers and board members
Leadership	Fundamental principles: • Leaders promote a focus on achieving healthcare excellence • Leaders create sufficient opportunities for board, executive and staff to engage in discussion, debate and reflection on healthcare quality • Leaders promote discussion of underperformance as opportunities to problem solve and improve Aspirational Principle: • CEOs model and actively promote opportunities to build respectful relationship between boards and executive staff
Evaluating healthcare quality taskwork	Fundamental Principles: • Quality healthcare is defined • A range of qualitative and quantitative data is reported addressing key dimensions of quality • Data from multiple sources and types is used to triangulate evidence • Date is trended, benchmarked and acceptable limits set where possible • Rationale for targets is transparent • Data is disaggregated to inform program specific performance • All data is accompanied by analysis of issues and identification of action (including no action required) • Board and quality committee reporting framework are transparent,

	reviewed and endorsed by the board • Committee adds value to board through highlighting areas of emerging healthcare variation or underperformance Aspirational Principle: • Dashboard supplemented by graphs that indicate trends, acceptable limits or targets • Management quality reports are structured to reflect organisational agreed dimension of quality or organisational priorities • Periodic governance reporting (e.g. annual) occurs on key clinical risks (program area or incidents such as falls or pressure areas, communication failures) • Periodic thematic reviews (e.g. annual) identify trends, themes and causative factors in data presented in regular reports (e.g. feedback, incidents) • Governing body oversee periodic internal assessment of quality healthcare in program areas • Acknowledgement and spread of good practice •
Overseeing quality priorities taskwork	Fundamental Principle: • Board endorse and monitor the implementation of limited number of specific and measurable planned strategic quality priorities • Governance oversight and resourcing of key emergent quality priorities • Committee oversees progress with key quality improvement priorities Aspirational Principle: • BQC adds value to board through highlighting emergent quality priorities
Governance taskwork	Fundamental Principle: • Board member orientation provided in healthcare quality • Agenda balances items for noting vs items for discussion/decision to allow time for discussion • Periodic scheduled review of reporting framework assessed against responsibilities of board/committee • Periodic scheduled review of board/committee effectiveness against responsibilities of board/committee Aspirational Principle: • All board members spend time on the board quality committee

Table 30: Fundamental and Aspirational Principles

An understanding of these principles, along with an appreciation of the complexity of factors influencing engagement, allow creative and tailored responses to strengthen governance to be developed. The art of governance is in selecting and developing mechanisms to support effective governance processes that are appropriate to an organisation. This is dependent upon both a deep understanding of governance theory and practice; and regular reflection on the factors influencing effective governance at the organisation at that time.

8.13 Chapter 8 Summary

This chapter has reviewed and refined constructs within the original conceptual framework to present the Healthcare Governance Performance Framework. The framework advances the understanding of effective governance of healthcare quality. Effective governance engagement was found to be related to how well taskwork processes were implemented. Senior management were critical to the effective implementation of these processes. A broad range of factors acting within and beyond the organisation to influence engagement was identified. Furthermore, unique combinations of input and teamwork mediating constructs were found to interact to influence engagement in these processes at each organisation, reflecting the organisational context.

The key characteristics of effective governance of healthcare quality are described as governing bodies that are focussed, engaged, vigilant and reflective. Fundamental and aspirational principles were then drawn from the analysis to provide practical guidance to health services in strengthening healthcare quality governance.

The next chapter, the conclusion, addresses areas for further research where the HGPF can be applied.

Chapter 9 Conclusion: Implications of the HGPF

9.1 Introduction

In this final chapter, conclusions arising from discussing the research findings are presented. The chapter begins with a brief re-statement of the research questions addressed and informed by this thesis. The conclusions are presented in the form of implications of the research findings for hospitals, and their governing bodies. Finally, some suggestions are made for future research to advance the understanding of effective governance of healthcare quality.

9.2 Understanding effective governance of healthcare quality

Patients are sometimes harmed in the course of receiving hospital care. Increased awareness of harm and a board's ultimate responsibility for healthcare quality have focussed attention on governance. Research in this field, while steadily growing over the last two decades, was shown to have a dominant focus on a limited set of governance processes. Survey evidence has previously indicated an association between boards more engaged in these processes and healthcare quality outcomes, but was unable to explain the observed variation in engagement (Vaughn et al., 2006; Jiang et al., 2009; Jha & Epstein, 2010; Jiang et al., 2012; Jha & Epstein, 2013). Emerging research, often using different research methods, has begun to illuminate a number of factors mediating engagement in healthcare governance (Dixon-Woods et al., 2013; Bismark & Studdert, 2014; Freeman et al., 2016; Jones et al., 2017; Leggat & Balding, 2017; Lee et al., 2018).

This thesis aimed to build on emerging research to investigate the characteristics of effective governance of healthcare quality in Australian public hospitals. Two specific research questions were posed to address this aim. The first question addressed how board members and managers worked together to govern healthcare quality. This question addressed the gap in a detailed understanding of processes associated with the tasks of governing healthcare quality. The second research question focused on why organisations vary in their engagement in governance processes by examining what factors influence engagement.

A conceptual framework was developed to guide the exploration of governance processes and influences on engagement. This thesis identifies a comprehensive range of processes related to two key tasks of healthcare governance. A range of input and mediating factors influencing engagement in taskwork processes are identified that interact in unique combinations in each case. The findings of the study are reflected in the Healthcare Governance Performance Framework (HGPF). The implications of the HGPF for hospitals, and for the institutions governing them, are addressed in the following section.

9.3 Implications for hospitals

The multiple constructs outlined in the HGPF supports organisational awareness that governance improvements are not made through simple adjustments to board composition or the adoption of board dashboards. Improving healthcare governance requires a sophisticated understanding of task objectives and sustained and ongoing efforts to evaluate, reflect and strengthen governance inputs and dynamics to enable engagement in a full range of taskwork processes. The HGPF will support health services in moving away from the widespread mimetic adoption of a few practices associated with high performing organisations presented in the literature and towards a more comprehensive and tailored response to the identification of current barriers to effective governance.

Principles have been provided in Table 30 that outline areas for hospitals to consider in strengthening governance. However, a major implication for hospitals is in understanding the nature of effective governance relationships. This thesis has demonstrated the importance of hospitals considering governance in terms of the board and management working relationship. The importance of both senior management in providing leadership for healthcare quality and the presence of skills and resources to undertake or assist the board in processes of governance was evident from the findings. This approach is more consistent with a stewardship view of governance. To address this collaborative way of working, hospitals need to develop a clear shared understanding of the tasks and associated processes of governing healthcare quality among both board members and senior management. Both groups of participants at the board table also need governance knowledge and skills to support

effective leadership, communication and reflection on the execution of healthcare and governance tasks.

9.4 Implications for institutions governing hospitals

The model of devolved hospital governance, with LHN boards created by the Australian Government in 2011, rests on the assumption that boards and management teams have all the capabilities to govern effectively. Variable engagement in governance processes demonstrated in this study indicates that this assumption is false. To govern effectively hospitals need legislation, regulation and guidelines that clearly articulate governance objectives, tasks and processes. They also need centralised support in the form of:

- data and methods to inform the evaluation of healthcare quality,
- opportunities and resources to develop board and management governance skills,
- evidence to drive effective change in governance and healthcare quality improvement practices.

9.5 Implications for research

The HGPF makes visible multiple factors at play in the relationship between governance and healthcare quality. In this way the framework extends on the work of previous governance frameworks (see Chapter 3, section 3.2) by providing a more detailed conceptualisation of a range of inputs, taskwork and dynamic factors influencing healthcare governance than previously described. The framework provides further justification for those (Chambers et al., 2013; Freeman et al., 2016; Millar et al., 2013) arguing the value of illuminating the dynamics and processes of governance. The HGPF fosters a move away from a limited focus on a few processes of healthcare governance obtained through survey methods and highlights the importance of how the key tasks of governance are enacted.

The study findings illuminate a pathway for a range of future research projects. Further testing of the HGPF will build the evidence base for its applicability to the Australian acute public hospital setting. The examination of this complex social phenomena is

context specific (Yin, 2009). Findings reflect the Australian context within which healthcare governance is undertaken. As noted in the discussion (see Chapter 8, section 8.10) there are limitations to theoretical generalisation. The framework will need to be trialled in both other geographical and healthcare contexts to determine its applicability to these contexts.

Two constructs in the framework require further research to confirm their likely influence on governance effectiveness. Sociocultural influences on governance were apparent in this study but not explored in a sufficient depth to draw definitive conclusions about their influence on governance. Similarly, as hospital governing bodies mature in their development and oversight of strategic quality priorities, further research is needed into board decision-making that occurs mainly in relation to this task. Detailed investigation of other constructs presented in the framework would strengthen the evidence base and deepen the understanding of how each construct influences governance.

Testing of the conceptual framework that occurred in the study was confined to inputs, taskwork and teamwork mediators. The output category of the framework, represented by individual, corporate governance and organisational-level outputs, remains untested. Development of validated corporate governance-level output measures of taskwork engagement or taskwork quality requires further research. The articulation of detailed processes of healthcare governance in the study could provide the basis for future development and validation of a tool to assess the quality of taskwork engagement. Similarly, measures of teamwork quality could be developed by modifying existing teamwork effectiveness tools to reflect constructs found to be influential in the healthcare governance context. As the availability of suitable measure of organisational healthcare quality improves in Australia, these organisational measures can be combined with corporate governance-level output measures to provide a more comprehensive approach to measuring governance effectiveness.

Lastly, as healthcare quality performance data matures in Australia, a clear next step would be to determine if any association exists between measures of taskwork quality and governance teamwork quality and healthcare quality outcomes. This could be undertaken through the development of a survey addressing constructs in teamwork

and taskwork categories and analysing their association with healthcare quality outcome measures. An analysis of the relative influence of each construct undertaken through factor analysis of survey items would clarify the relative importance of constructs in the framework. The literature presented highlights evidence of a small but significant positive association of measures of healthcare quality and board engagement in a limited number of governance processes (see Chapter 2, section 2.4.2). Further research on the relationship between taskwork and teamwork quality and clinical outcomes would build on this evidence. The reduction in harm to patients is ultimately, the rationale for undertaking research in this area.

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Appendix 1a: Interview Plain Language Statement

Participation Information and Consent Form

Project: Governing the quality of care in Australian public healthcare organisations

What is the study about?

This project aims to make recommendations to strengthen the governance of healthcare quality in Australian public hospitals. It will do so by examining two broad questions. First, 'How do managers and boards work together in governing the quality of care?'. Secondly 'To what extent are desirable team effectiveness characteristics present in the board and management governance of quality?'. The project involves multiple case studies of de-identified hospitals with a range of structures, approaches and outcomes in relation to quality of care.

This study is conducted as part of the principle researchers candidacy for a PhD. The project has been approved by the University of Melbourne Human Research Ethics Committee.

Who is carrying out the study?

The study is being carried out by the following researchers:

- Alison Brown, PhD candidate, Centre for Health Policy, School of Population and Global Health, University of Melbourne
- Professor Margaret Kelaher (Supervisor), Director, Centre for Health Policy, School of Population and Global Health, University of Melbourne
- Associate Professor Helen Dickinson (Co-supervisor), School of Government and School of Social and Political Sciences, University of Melbourne

What does participation involve?

Participation involves an interview with Alison Brown, which will last approximately 60 minutes. The interview will be seeking your perspectives, based on your role as a participant in the board quality committee, on the way in which the boards and managers work together to govern the quality of healthcare at your organisation.

We will be conducting interviews at a time and location convenient to you. Interviews can be completed over the phone or face-to-face. With your permission, the interview will be recorded so we can ensure we make an accurate record of what you say.

What about privacy and confidentiality?

We intend to protect your anonymity, and the confidentiality of your responses, to the fullest extent possible within the limits of the law. Your name and contact details will be kept in a separate, password-protected computer file at the Melbourne School of Population and Global Health, and will be stored separately to any data you supply. Only the above-listed researchers will have access to this data.

No publications, presentations or other public reporting of results will identify you individually, or any organisation you are associated with. Results will be presented in aggregate form. All data will be reported in an anonymous and non-attributable manner. All identifying data associated with this project will be destroyed five years after the project is complete.

What will the outputs of the study be?

We anticipate that findings from this study will be published in scientific papers and PhD thesis, and presented and discussed at conferences. A summary report of the findings will also be provided to study participants.

Each hospital participating in the interviews will receive a summary report of their own hospitals governance of quality that may be useful in reviewing the governance quality framework and could be useful in addressing *Standard 1: Governance for safety and quality in health service organisation* in the national safety and quality health service standards.

Do I have to participate?

No. Participation is completely voluntary. If you choose to participate, your choice is completely voluntary. Should you wish to take a break during the interview, or withdraw from the study during the interview, you are free to do so. You are also free to withdraw your data until the data has been processed. If you do not

withdraw your data before processing, it will be included in the study. If you decide that you do not want to participate in the study, or you wish to withdraw, you do not have to give a reason.

Where can I get more information?

If you have any questions or concerns about the research or technical aspects of the project please do not hesitate to contact us at:

Alison Brown
PhD Candidate
Centre for Health Policy
Melbourne School of Population and Global Health
Mobile 0409 150 200
E mail: alisonb2@student.unimelb.edu.au

Professor Margaret Kelaher
Director, Centre for Health Policy
Melbourne School of Population and Global Health
Phone: 03 8344 0648
Email: mkelaher@unimelb.edu.au

This research project has been approved by the Human Research Ethics Committee of The University of Melbourne. If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact the Manager, Human Research Ethics, Office for Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Fax: +61 3 9347 6739 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially. In any correspondence please provide the name of the research team or the name or ethics ID number of the research project

Appendix 1b: Interview Consent Form

CONSENT FORM

Project:	Governing the quality of care in Australian public healthcare organisations
Principle researcher:	Alison Brown, PhD candidate
Other researchers:	Prof Margaret Kelaher, A/Prof Helen Dickinson
Version:	April 2016

In signing and returning this form to the researchers, I acknowledge that:

1. I understand that this project is for research purposes.
2. I have read and understood the Participation Information provided for this project. I have been given a copy of the Participation Information and the Consent Form to keep.
3. I freely agree to participate in this project, according to the conditions laid out in the Participation Information, and this Consent Form.
4. I understand that participation in this study is voluntary, and I can withdraw myself and/or my data from the study at any time before three weeks after the interview date, without affecting my relationship with the researchers now or in the future.
5. I consent to the interview I participate in being recorded for transcription purposes.
6. I understand that I will be shown the extracts from my recording for verification purposes
7. I understand that - to the fullest extent possible within the law - the researchers will not reveal my identity, or personal or organisation details, if information about this project is published or presented in any public form.

Participant (please print): .....

Organisation:.....

Signature: ..... **Date:** .....

☐ Please tick if you would like a summary of the results emailed to you at the conclusion of the research project. If so, please provide an email address below.

Email address for summary of results:

……

Appendix 2: Observation Plain Language Statement

Research Information

Governing the quality of care in Australian public healthcare organisations

We invite you to participate in research examining the governance of the quality of care at your hospital or network. As part of the research the researcher will observe meetings of the board committee responsible for quality of care. The purpose of the observation is to understand in greater depth the work of the board, senior management and senior clinicians in governing the quality of care.

What is the study about?

This project aims to make recommendations to strengthen the governance of healthcare quality in Australian public hospitals. It will do so by examining two broad questions. First, 'How do managers and boards work together in governing the quality of care?'. Secondly 'To what extent are desirable team effectiveness characteristics present in the board and management governance of quality?'.

Who is conducting the research?

This research is conducted by Alison Brown. Alison is a PhD student at the University of Melbourne and is funded by an Australian Postgraduate Award. Alison's supervisors are:

Professor Margaret Kelaher (Supervisor), Director, Centre for Health Policy, School of Population and Global Health, University of Melbourne

Ass Prof Helen Dickinson (Co-supervisor), School of Government and School of Social and Political Sciences, University of Melbourne

What does the observation involve?

The researcher, Alison Brown, will attend a minimum of one meeting of the board committee responsible for quality of care. At the meeting the researcher will make notes of observations of the meeting. No audio or video recording of the meeting will be taken.

What about privacy and confidentiality?

Your identity will not be revealed in any publications arising from this research. We will store the data from all observations for five years at the University of Melbourne, after which it will be destroyed

Do I have to participate?

If you choose to participate, your choice is completely voluntary. If you decide not to participate in the observation no information related to your input to the meeting will be recorded. If you should choose later to withdraw, you will not be disadvantaged in any way, and we will not use any unprocessed information you have provided.

Where can I get more information?

If you have any questions or concerns about the research or technical aspects of the project please do not hesitate to contact us at:

Alison Brown: Phone 0409 150 200, E mail: alisonb2@student.unimelb.edu.au

Professor Margaret Kelaher: Phone: 03 8344 0648, Email: mkelaher@unimelb.edu.au

This research project has been approved by the Human Research Ethics Committee of The University of Melbourne. If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact the Manager, Human Research Ethics, Office for Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Fax: +61 3 9347 6739 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially. In any correspondence please provide the name of the research team or the name or ethics ID number of the research project

Appendix 3: CEO letter

[Date], Chief Executive Officer,[Health Service]

Dear [CEO]

Re: **Request for participation in 'Governing the Quality of Healthcare' research project**

I am writing to request your organisations involvement in a research project which aims to explore how boards and senior management work together to govern the quality of care. The project will involve case studies conducted at a small number of public hospitals that vary in the processes, structures and outcomes in relation to quality of care and will involve interviews with quality committee members and a review of governance documentation.

The research will identify the characteristics of the effective governance of healthcare quality and will inform recommendations to strengthen the governance of healthcare quality. Organisations agreeing to participate as a case study will receive an organisation specific report on their governance of healthcare quality which may be useful to the organisation in reviewing their governance systems and may also be useful in addressing aspects of *Standard 1 Governing for Safety and Quality* in the national standards.

The research is being undertaken, under my supervision, by Alison Brown, PhD candidate. Alison has worked as a clinician, quality manager and more recently as a consultant with the Australian Centre for Healthcare Governance. Alison has a Master of Public Health and is also a graduate of the Australian Institute of Company Directors.

Information about the project, the extent of your organisations involvement in the project and the confidentiality and privacy protocols are in attachment 1. If you are interested in participating Alison will provide more detailed information including the University of Melbourne ethics approval and explanation and consent forms for interviewees. Alison would welcome the opportunity to discuss this with you and/or your board chair and can be contacted on (M) 0409 150 200 or e mail alisonb2@student.unimelb.edu.au

Many thanks for your consideration of this request

Yours sincerely

Professor Margaret Kelaher

Director of the Centre for Health Policy

School of Population and Global Health

University of Melbourne

Appendix 4: Interview schedule

Questions	Prompts
I understand your position on the quality committee is as a (chair/voting member/attending role)	What drew you to being on this board
How long have you been with the board/organisation?	How long have you been attending the quality committee meetings (in months)
Can you tell me about your professional background?	(For staff) how did you get interested in quality or clinical governance?
Who or what drives the focus on quality and safety at this organisation? (from among board members, senior managers, senior clinicians and CEO)	Are there other individuals that are influential? Yes/ no question is no good To what extent does the CEO drive the focus on quality and safety?
(Board members only) Can you tell me about any orientation or training you have received coming on to the board in: • clinical governance/quality improvement and data analysis • teamwork	How confident and prepared do you feel to discuss quality and safety issues with the management team?
There are a range of skills and experience of board members in quality and safety is this an advantage or a challenge to CG? (staff only) Can you describe the strategies have you have used to assist board members to understand clinical governance and quality improvement or data analysis? What about the skills of the senior executive in quality and safety?	How well have these strategies worked Are these the right skills and experience for clinical governance? What is missing? What about skills in understanding quality improvement science or clinical data
What is your job in relation to quality? What do you believe are the fundamental roles of the board in governing the quality of clinical care? Any others? (Strategy, Performance, Culture, Systems and resources)	What is the purpose of this activity? Can you give me an example of where you think the board has had a significant influence in driving the direction of quality?
How do you identify and implement strategic improvements to quality of care? Are there any specific strategic priorities/goals that relate to the improvement of an aspect of the quality of services? Do the strategic priorities/goals have measurable targets? Are they influential in driving the direction?	To what extent is the board or quality committee involved in the development or shaping of strategic or high-level priorities for quality?
How do you review if information on quality and safety you are getting is useful at the board level?	Does the board debate the measures received
Moving to thinking about the quality committee	

What role does the quality committee play in governing the quality of care? Does the agenda allow you to focus on those important tasks?	What does it add above and beyond the operational level committees or the board? Can you give me an example of where the quality committee has had a significant influence in driving the direction of quality
How do you review if the information you are getting is useful at the committee level? Do you review the reporting framework/calendar of reporting as a whole?	To what extent are committee members involved with that decision Do you discuss the format and frequency of data presentation
How do you review the committee effectiveness?	
How would you describe the relationship between board members and managers? How does that effect the work done?	
How comfortable or easy do you think it is for managers to discuss issues that have been identified with the quality of care /How comfortable or easy is it for board members to questions or delve into data presented at the quality committee level?	And at board level? Some people say they find it difficult other have said they find it easy, how about you?
Which of the following represents communication at the quality committee? • Brief efficient discussion of information presented • Lively open debate of information presented • Limited time or opportunities for further discussion	
If differences of opinion arise when discussing the quality of care how are they handled?	At the board or quality committee? How are they handled, openly or does it lead to conflict?
On a rating of 1 -10 to what extent do you think the quality committee makes a difference to the governance of quality (with 10 making a great deal of difference to 1 being very little difference)?	Can you tell me what you were thinking about as you gave it that rating? What, if anything, would you like to see changed?
On a rating of 1 -10 to what extent do you think the work of the board makes a difference to the governance of quality (with 10 making a great deal of difference to 1 being very little difference)?	Can you tell me what you were thinking about when you gave it that rating? What, if anything would you like to see changed?
Apart from the minutes what other ways does information pass from quality committee to the board?	e,g, discussion papers, verbal chair report and recommendations?
That covers my list of questions is there anything you would like to add? Or that you would have liked me to ask but didn't	

Appendix 5: Observation Template

Org ID

Date

Time

Duration

Location

Room set up

Chair (position)

Participants

Leadership style

Decision-making

Meeting objectives awareness

Atmosphere

Engagement/Interest

Respect/Cohesion

Trust/Safety

Conflict/Tensions (task or interpersonal)

Verbal Communication

Framing of quality issues

Listening

Participant contributions

Constructive debate/no disagreement/disagreement

Non-Verbal communication

Taskwork

Quality performance analysis/identification of underperformance/development of action

Quality planning /strategy

Appendix 6: Case template

Feature	Description
Case	
Beds	
Annual Budget	
Description from SOP	
AIHW category	
Size	
Relevant organisational background information	
Organisational structure	
Governance structure/committees	
Board composition	
Who sits at board meetings	
Board agenda structure	
Structure for quality	
Quality Definition	
Quality Framework	
Board quality responsibilities	
Board member quality orientation	
Board quality schedule/workplan/calendar (broad	
Board agenda structure	
Quality data reporting framework (with agreement on format, frequency and responsibilities)	At board At BQC
Board quality scorecard/dashboard?	
Who sees the scorecard/dashboard?	
Reporting Frequency	
Trending data	
Benchmarking data	
Target set	
Issues identified on the scorecard/dashboard with follow up corrective action with responsibilities and timelines?	
Report on the progress of corrective actions	
Period presented in scorecard/dashboard	
How often is scorecard/dashboard reviewed and who endorses?	
How is information determined to be useful?	
Other key reports identifying quality issues at Board	
How are issues identified from other key	
Broader action follow up mechanism for all other reports	
Board focus on quality	
Risk management	
BQC Responsibilities	
BQC agenda	
BQC new member orientation	

Feature	Description
BQC Schedule	
Who sits at the BQC?	
BQC quality scorecard/dashboard?	
Mechanisms for identifying quality issues at BQC (note how data presented)	
Mechanisms for action on quality issues at BQC	
Communication between BQC and board	
Committees reporting to BQC	
BQC review processes	
Planning architecture	
Strategic Planning	
Measurable time limited objectives/goals for quality from aims	
Process for operationalising strategy (dissemination and alignment of measurable objectives)	
Process for monitoring achievement of measurable	
Org communication re strategic progress	
Periodic review of strategic objectives	
Quality Improvement Plan	
Impressions	
Quality initiatives of note	
Questions For interview	
Interesting issues	
Questions at other time	
Follow up by me	
Follow up/Documents needed	

Appendix 7: Codebook

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
INPUT - individual	Knowledge skills and abilities (KSA)	Background	University qualifications/Experience/ employment history related to the healthcare field	Influence of professional knowledge on board member/manager effectiveness	Governance, Clinical and non-clinical qualifications and background experience
	Knowledge skills and abilities	Orientation	Provision of formal program of orientation to new board members	Influence of presence/absence board member orientation	Board or committee
	Knowledge skills and abilities	Skills development	Knowledge or Training in governance responsibilities	Influence of presence/absence training on effectiveness	Governance such as finance, risk, Improvement methodology- may include Lean, six sigma, PDSA, TQM Data analysis- may include VLADS Statistical process charts, statistics Clinical governance Teamwork skills
INPUT – board/ committee	Structure	Board meeting composition	regular participants or as required attendance at board meetings	Influence of management, Unit heads, senior clinicians attendance at board meetings	Executive team, Senior management, clinical leaders and clinicians (background of board member is covered in background and also actual numbers of clinical vs non-clinical could be covered in excel sheet)

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
	Structure	Board time	Frequency, duration or timing or board meeting	Influence of scheduling of board meeting	
	Structure	Other Governance committee			e.g. other board committee
	Structure	Committee composition	Number or type of members on board quality committee	Influence of composition of regular attenders and as required presenters	Board and management members
	Structure	Committee time	Frequency, duration or timing of board quality committee	Influence of scheduling of committee meeting	
INPUT organisation	Resources	Quality workforce and org structure	Availability of workforce and technical skills to undertake quality improvement Structure of quality in org structure of executive	References to number or competency of quality workforce References to operational committee or CG units Reference to executive structure Reference to physical location	
	Resources	Information provision	Ability to produce data required or requested	References to data analysis capability	
INPUT: external context	Regulatory bodies	Regulatory and other state/national bodies	Bodies that impose compliance requirements, policy or supervise health service	Influence of regulatory on board, board quality committee or senior management level clinical governance	state health department via performance agreements and policies state funded bodies such as Coroners court, complaints

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
					commission, VMIA, CEC, BHI National bodies such as Australian commission of safety and quality, Professional bodies, AHPRA Influence of State based health or health service related legislation Includes reference to previous structures that were in place such as advisory boards for NSW
	Accreditation	Accreditation	Formal accreditation processes occurring in the organisation	influence of accreditation programs through national standards, dental, aged care etc	
	Evidence	Evidence	reviews of high profile health services failures or Peer reviewed clinical governance literature	Influence of findings of high profile reviews and academic literature related to quality in healthcare and governance	at board, board quality committee or senior management level clinical governance
	Socio-cultural	Remuneration	Influence of Remuneration at board, board quality committee or senior management level clinical governance	Management salary or board member remuneration	
	Socio-cultural	Gender	Influence of Gender at board, board quality committee or senior management level clinical governance	Male or female influence	
	Socio-cultural	Status	Influence of status at board, board quality committee or senior management level	Management hierarchy, clinician vs non-clinician, perceived external status	

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
			clinical governance		
	External context	Other			
Mediators: taskwork	Monitoring Performance	Quality Definition	Dimensions of quality of interest to the organisation		
	Monitoring Performance	Selection of data	Process for selecting quality data for inclusion in reports to board and committee	References to management and/or board input into data selection, use of schedule of data. Factors Influencing selection e.g. dimension or domains of quality risks	Includes review processes
	Monitoring Performance	Robustness of data	The validity and reliability of data	References to strength of weaknesses of data	
	Monitoring Performance	Format of data	Methods and impact of formatting quality data at board or board quality committee level	References to presentation of quality data and references to ease or difficulty of interpreting data presented	Trending, benchmarking, scorecard, dashboard, narrative analysis
	Monitoring Performance	Identification of problem areas and areas of excellence and action	Processes for identifying follow up action in relation to issues/problem areas	References to strategies for identifying issues/problems and areas of strength	Action list, traffic light, narrative report etc
	Monitoring Performance	Monitoring action	Report on the progress of corrective actions to address issues identified	Reference to processes to follow up on corrective actions	Action log, agenda standing items for follow up of action in minutes. plan
	Quality Planning	Strategy development and review	Board or management involvement developing strategic quality priorities as	Reference to active involvement of board/committee	Includes formal and non-formal stages of development and review (reflective practices)

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
			part of strategic or quality planning at board, board quality committee or senior management level		
	Quality Planning	Measurable strategy	Development of strategic priorities whose progress/success on implementation can be measured	Reference to board discussion of format of strategic priorities	
	Quality Planning	Strategy influence	Strategic quality priorities influencing work of board quality committee or senior management	Reference to dissemination of influence of strategic priorities at clinical governance committee or senior executive	In operational plan or other activities such as that of board or committee (or lower down but less relevant to my study but relevant to the aim of strategy)
	Quality Culture/focus	Promoting quality culture	Promote or measuring a culture of quality and safety in the health service	Reference to activities to promote quality culture Focus on quality	
	Quality Systems	Quality systems	Processes to check effectiveness of quality systems	Reference to review of effectiveness of quality systems	Such as Credentialing, incident management, risk management, staff development, complaints
	Governance	Governance tasks	Standard governance tasks required of any board	Reference to board or committee evaluation, development of annual calendar, risk review, CEO performance review	Operational Committee reporting Operations vs governance argument
Mediators: teamwork	Behavioural processes-	Leadership	Characteristics related to leadership of the board or	Knowledge of role, experience of leadership role, style of leadership, influence of leaders	board or committee or CE (a focus on quality)

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
			committee	which may be of formal leader chair or others who are perceived leaders at Board or committee.	
	Behavioural processes	Communication	Formal and informal, non-verbal and framing of communication at board or committee	Agenda, board papers, board meeting communication style (open transparent, willing), other meetings. Issue of governance vs operations	Includes openness and framing
	Behavioural processes	Decision making	Existence of and processes for decision making at board or committee	Influence of decision making such as Vote, consensus, discussion, power of decision making	
	Affective emergent states	Trust	The perceived safety and efficacy/potency that exists at the board or board quality committee level	Reference to presence/ absence of trusting, reliable, safe, supportive environments or lack of trust	
	Affective emergent states	Cohesion	Commitment to the task and the board/committee	Reference to presence/ absence of commitment to a task, interpersonal liking	
	Affective emergent states	Respect	Admiration b/w board and managers, board and CEO, CEO and managers	Reference to presence/ absence of Respect	
	Affective emergent states	Challenge	Challenge of information presented to the board or board quality committee	Reference to presence/ absence of requests for clarification, further explanation or data robustness	

Conceptual Category	NVivo Parent Node	NVivo Child node	Definition	Inclusion criteria (Include if discusses…..)	Notes
	Affective emergent states	Conflict	Task related or relationship conflict	Reference to presence/ absence of conflict arising in processes of governance, relationship conflict, managing conflict	
	Cognitive emergent states	role understanding:	understanding of the role and responsibility of the board or quality committee in clinical governance or governance more broadly	Reference to understanding of role and presence/ absence of shared understanding of board role	
	Cognitive emergent states	task understanding	understanding of the tasks of the board quality committee in clinical governance		
Output	Organizational level	Quality and safety performance	Measures of quality and safety at an organisational level		
	Board level	Board performance	Assessment of board performance		Board or director or committee performance
	Management level	Management performance	Assessment of management performance		CEO or executive

Appendix 8: Published article

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Governing the quality and safety of healthcare: A conceptual framework

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ABSTRACT

Recent research has advanced understanding of corporate governance of healthcare quality, highlighting the need for future empirical work to develop beyond a focus on board composition to a more detailed exploration of the internal workings of governance that influence board engagement and activities. This paper proposes a conceptual framework to guide empirical research examining the work of board and senior management in governing healthcare quality. To generate this framework, existing conceptual approaches and key constructs influencing effectiveness are identified in the governance literature. Commonalities between governance and team effectiveness literature are mapped and suggest a number of key constructs in the team effectiveness literature are applicable to, but not yet fully explored, within the governance literature. From these we develop a healthcare governance conceptual framework encompassing both literatures, that outlines input and mediating factors influencing governance. The mapping process highlights gaps in research related to board dynamics and external influences that require further investigation. Organizing the multiple complex factors that influence governance of healthcare quality in a conceptual framework brings a new perspective to structuring theory-led research and informing future policy initiatives.

1. Introduction

Boards of healthcare organizations are increasingly recognised as important in driving healthcare quality and are the focus of this paper. A board is defined as a group of people charged with legal and constitutional responsibility for governing an organisation (Governance Institute of Australia, 2016). While governance can occur at multiple levels within and external to an organisation, boards are a formal mechanism of corporate governance. Although the literature details a multitude of factors thought to influence the governance of healthcare quality, there is no single conceptual framework that integrates these factors. This paper aims to address this gap through developing a conceptual framework for healthcare governance. Such a framework may be used to guide a theory-led approach to examine the ways in which key factors in the framework 'fit together' to influence the governance of healthcare quality (Dickinson and O'Flynn, 2016).

In setting out our argument we begin by describing the contribution of boards to healthcare quality performance, outlining the factors thought to influence the effectiveness of healthcare governance. Traditionally board research has typically had a strong focus on their composition, but more recent research turned its attention to the internal processes and dynamics of boards; the 'black box' of governance (Buechner et al., 2014; Freeman et al., 2016; Millar et al., 2015). What this indicates is an acceptance of the need to move beyond structural factors to focus on the range of other factors that influence discussion and decision-making within boards (Freeman et al., 2016; Chambers et al., 2013; Cornforth, 2012; Millar et al., 2013). We argue that the development of a conceptual framework can provide a tool to explore both the internal processes and dynamics influencing effective governance of healthcare quality and, broader social and cultural influences.

The structure for such a framework is derived from an existing team effectiveness conceptual framework. The resulting conceptual framework, the Healthcare Governance Performance Framework (HGPF), provides a comprehensive structure for undertaking theory-led research and we conclude by setting out some avenues for future research utilising the HGPF.

1.1. Healthcare governance in context

Recent decades have seen an increased understanding of the level of preventable harm associated with hospital care (Department of Health, 2000; Kohn et al., 2000; Wilson et al., 1995; Wilson and Van Der Weyden, 2005). In the United States, failures in healthcare have been associated with negligence on the part of both individual physicians and hospitals, as in the case of Redding Medical Centre, California

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where significant unnecessary cardiac surgery was undertaken resulting in substantial settlements to victims in 2004 (Klaidman, 2007; Walshe and Shortell, 2004). A common theme emerging from formal inquiries of such high profile hospital safety issues is failure in leadership at multiple levels, including the board, to actively monitor quality of care and ensure accountability.

The Francis review into failings at Mid Staffordshire hospital in the UK, found a lack of effective board leadership resulted in 'appalling care for patients' (p.1588) (Francis, 2013a). An earlier inquiry into mortality rates among pediatric cardiac patients at Bristol Infirmary found a board uninvolved in reviewing information about outcomes of care (Hindle et al., 2006). Similarly, Botje (Botje et al., 2013) outlines examples of poor quality hospital care in the Netherlands relating to a lack of sufficient board focus on the quality of care. These cases clearly point to the important contribution of boards in governing healthcare quality and the impact when that role is not enacted effectively.

Governments have responded to concerns of quality, outlining a number of board requirements. In the US, for example, to receive Medicare funding hospitals must demonstrate compliance with conditions of participation which specifically mention a board role in ensuring the quality program is sophisticated, reflects the complexity and service profile of the organization and has indicators related to outcomes and reducing medical errors (Condition of participation). In the UK, the Health and Social Care Act has significantly increased the focus on quality, with accompanying regulations enabling the regulator to initiate criminal charges if health services breach a set of fundamental standards (Quality Care Commission, 2014). The board's ultimate responsibility for the quality of care is clearly stated in government guides outlining these changes (National Quality Board, 2013).

With boards being more explicitly recognized as have a role in, and ultimate responsibility for, quality of services, a rapidly growing literature has emerged outlining factors associated with effective healthcare governance (Millar et al., 2013). Research on governance effectiveness factors can be divided into two main groups: input and mediator research. Input research refers to the features of a board, encompassing individual board member characteristics and factors relating to their resourcing and structure. Mediator research focuses broadly on the internal processes and dynamics of boards.

In the empirical governance literature, input-related research has examined the influence of relevant board skills through clinical composition of boards (Prybil, 2006; Veronesi et al., 2013, 2015) and training in quality (Bismark et al., 2013; Jha and Epstein, 2010; Jiang et al., 2012). While these factors have been demonstrated to influence governance engagement and are associated with improved quality outcomes, there is a growing interest in mediating board processes, which are arguably less understood. Empirical research has highlighted variable engagement of boards in a number of activities associated with governing healthcare quality (Bismark et al., 2013; Jha and Epstein, 2010, 2013; Jiang et al., 2008). Research mainly undertaken in the US, using cross sectional surveys, has demonstrated a small but positive association between board engagement in quality activities and quality of care outcomes (Jha and Epstein, 2010; Jiang et al., 2009, 2012; Prybil et al., 2010; Vaughn et al., 2006). Greater engagement in quality is demonstrated, for example, through more time spent discussing quality or, review of quality performance reports (Jha and Epstein, 2010; Jiang et al., 2012; Vaughn et al., 2006). While important steps have been made in understanding the association between engagement in quality activities and quality outcomes, our understanding of what is driving variable engagement of boards in health care quality activities is underdeveloped.

The act of governing is a complex interplay of social relationships, knowledge asymmetries and forms of power between individuals with differing backgrounds, expertise, perspectives and traditions. These factors, along with broader social, political and cultural influences arising in the organization and external environment, shape governance activities. Qualitative research has provided valuable insights into mediating factors that influence board engagement in quality activities. Factors such as communication and interpretation of quality issues at the board table (Freeman et al., 2016) and relationship dynamics between the board and senior managers (Millar et al., 2015) have been identified as mediators of healthcare governance effectiveness. This emerging research, explored in more detail later in the paper, highlights the value that these research methods bring in illuminating subtle mediating factors relating to the dynamics of governance.

1.2. Board and management relationship

Much of the research into healthcare governance has focussed on the board and, to a lesser extent, the CEO (see for example (Prybil, 2006; Jha and Epstein, 2010; Jiang et al., 2008)). Yet, in the broader governance literature, the relationship between board and management has long been of interest. Agency theory, highlights the potential for self-interested behaviors by managers and the need for boards to hold managers to account (Chambers et al., 2013). Stewardship theory, in contrast, views the motivations of boards and managers as aligned, with managers who understand the business contributing to effective decision-making (Nicholson and Kiel, 2007). Thus, an evidence base is emerging demonstrating a link between board and managers in governing healthcare quality. For example, Weiner et al. (1996) found that CEO involvement in quality activity increased board quality activity. Botje et al. (2014) found that stronger quality management systems were associated with more frequent discussion of quality performance at the board. Tsai et al. (2015) found that boards more engaged in quality were significantly positively associated with the management practices of monitoring, operations and target setting. These studies provide early evidence of the interrelatedness of the quality activities of board and senior management.

Research also highlights the importance of the board and management relationship in healthcare governance. In investigating board and management collaboration in strategy development, Buechner et al. (2014) asked questions related to communication, cooperation, length of decision-making and board involvement in operational decision-making, finding a significant relationship between the quality of board and management collaboration and hospital financial and efficiency performance. In a detailed case study of the performance of four UK NHS boards, Freeman et al. (2016) found considerable variation in processes of framing and interpreting quality data at the governance level, which reflected aspects of board and management relationship.

The literature described indicates the value of expanding the scope of governance research beyond the board. This is particularly pertinent for boards comprised mainly of non-executive directors, who by necessity must work closely with senior management to govern quality of care.

1.3. Team effectiveness theory

A range of conceptual frameworks for governance may be found in the literature and these share commonalities in construct categorization (Chambers et al., 2012, 2013; Cornforth, 2001; Murray, 2004). In one of the most widely known contributions, Cornforth (2001) proposed and tested an input, structure and process, and output categorization of key constructs for board performance in the not-for-profit sector. In a review of healthcare governance literature, Chambers et al. (2013) outline a categorization of a number of key factors relating to composition, focus and dynamics.

The emphasis on different factors in existing frameworks can be resolved through developing a new conceptual tool that builds on the strengths of existing frameworks, while at the same time bringing new perspectives informed by emerging research. The starting point for this is in referencing a well-developed conceptual framework in a related field, in line with previous conceptual research (Nuckols et al., 2013; Wendt et al., 2009). Governance research, highlighting factors related

to the board inputs, dynamics and processes, bears striking similarities with the team effectiveness literature.

The work of a board has increasingly been viewed as a team endeavour (Conger and Lawler, 2009; Forbes and Milliken, 1999; Kay and Goldspink, 2015; Payne et al., 2009). Boards have many features in common with teams, as the commonly cited criteria in the definition provided by Hoegl and Gemuenden (2001) demonstrates. These authors describe a team as a 'social system of three or more people, which is embedded in an organization (context), whose members perceive themselves as such and are perceived as members by others (identity), and who collaborate on a common task (teamwork)' (p. 436) (Hoegl and Gemuenden, 2001). While boards may not describe themselves as teams, they are a defined group of people identifiable in the health service who meet regularly to undertake interdependent tasks in governing healthcare quality.

Team theory has been widely used in healthcare research in understanding the influence of clinical working relationships on service delivery, where groups of professionally- or functionally-aligned clinicians are envisaged as teams (Alexander et al., 2005; Benson, 2010; Gittell et al., 2013; Körner, 2010). Teamwork literature derives from a vast body of research in psychology, organizational theory and management. The theoretical literature examining teams, although vast, is reasonably consistent in organising key constructs influencing effectiveness according to categories based on inputs which are transformed through intermediate processes into outputs of teams (Kozlowski and Ilgen, 2006; Mathieu et al., 2008). An early input, process and output (IPO) model of team effectiveness, developed in the 1960's, has been adapted over time to reflect a greater understanding of the range of variables influencing team effectiveness, interactions between variables and a broader interpretation of outputs (Kozlowski and Ilgen, 2006; Mathieu et al., 2008). Subsequent models share mostly similar key constructs, but can vary in allocating these to categories and in portraying interactions between categories (Marks et al., 2001; Mickan and Rodger, 2005; Senior and Swailes, 2007).

The Input-Mediator-Output-Input (IMOI) model, presented in Fig. 1, has been chosen as the basis for developing a healthcare governance framework. The IMOI model is a useful team effectiveness model in portraying the non-linear relationship and cyclical interplay between variables over time (Ilgen et al., 2005). Processes of teams are represented as a range of teamwork mediators comprising behavioural processes involving actions or interactions between team members, and emergent states that are attitudes, motivations or thought processes (Marks et al., 2001). Refining intermediary variables in the IMOI model into emergent states and behavioural processes provides a useful model for separating out processes of governance from affective and cognitive states that arise as board members and managers interact. The model indicates how these may, in turn, influence each other and the outputs of governance.

The purpose of using team theory is to provide a starting point to develop a new conceptual framework. However, limitations exist in using team theory, even the more agile IMOI model, to represent the complex socio-cultural phenomenon of healthcare governance. Critiques of the dominance of mechanistic approaches, such as team theory, to improving healthcare quality and safety have emerged over the last few years (Braithwaite, 2006; Waring et al., 2016). Waring et al. (2016) acknowledge the contribution of these types of approaches to knowledge of organizational level factors but argue that a sociological lens can illuminate a broader range of social, political and cultural factors that may be important in healthcare but have received scant attention to date. This highlights the danger inherent in thinking that a simple modification to a few organizational factors, through a linear mechanistic approach to problem solving, would result in improved governance. The new framework will address the limitations of its more mechanistic origins through making visible the multiple and multilevel factors that influence healthcare governance effectiveness.

2. Developing a conceptual framework

The first step in developing the healthcare governance conceptual framework requires a comprehensive review of team literature to identify commonly cited constructs related to the broad categories presented in the IMOI model. For example, while trust is also described in the team literature as efficacy, potency and safety, the term 'trust' and 'safety' were the most commonly used forms. A literature search was conducted of English language papers from 1990 onwards using electronic databases Medline/PubMed and Google Scholar and hand searches of reference lists of relevant papers. The search categories and specific terms used are presented in Table 1. Once key team constructs were identified, subsequent literature searches were undertaken to locate the occurrence of team constructs in healthcare governance literature.

Rather than report raw numbers, we have indicated the degree to which constructs have been considered within the literature according to a categorisation based on the volume of sources that feature this construct as outlined in the legend accompanying tables. While not assessing the quality of the studies, this approach highlights some

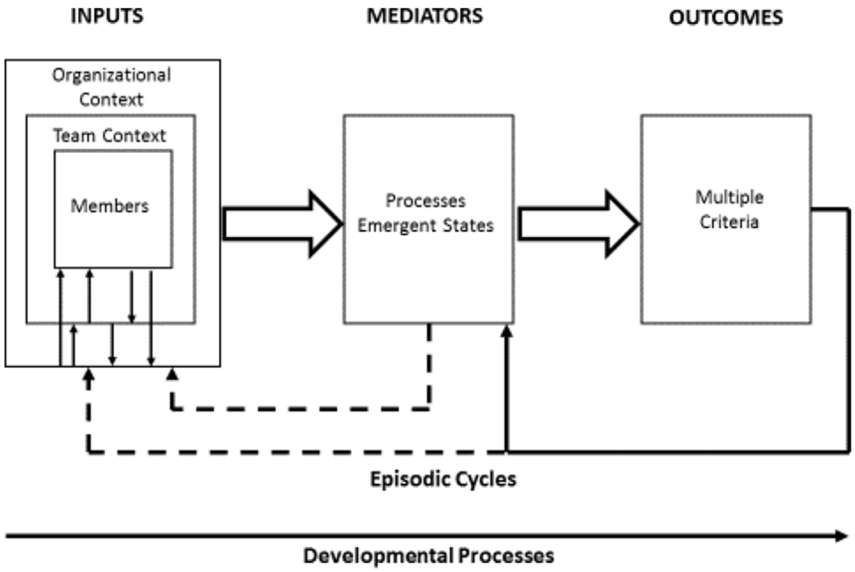

Fig. 1. IMOI model from Mathieu (Mathieu et al., 2008).

Table 1
Categories and search terms used in literature searches.

Category	Search Term
Teams	"Team*" OR "Team effectiveness"
Team Constructs	"Outcome" OR "Performance" OR "organi?ational performance" OR "Measurement" OR "Monitor*" OR "Quality indicators" "Strateg*" OR "Priorit*" OR "Goal*" OR "Objective*" "Knowledge" OR "Skill*" "Composition" "Purpose" OR "Shared Objective*" OR "Shared Goal*" "Leader*" "Communication" "Decision Making" "Trust OR "Safety" "Cohesion" OR "Respect" "Conflict" OR "Conflict management"
Governance	"Board*" OR "Govern*" OR "Trustee" OR "Director" OR "Governing Board"
Healthcare	"Hospital" OR "Health care" OR "Delivery of health care"
Quality and Safety	"Quality and safety" OR "Patient safety" OR "Quality improvement" OR "Clinical governance" OR "Quality of health care"

current gaps in healthcare governance research. The result of this mapping is described below and includes suggested modifications to the IMOI model in developing a framework relevant for healthcare governance research.

2.1. Inputs

The IMOI model outlines multiple inputs at individual, team and organizational level that may influence team effectiveness. An individual level input is the knowledge, skills and abilities (KSAs) of individual team members. KSAs are described as either technical, related to task execution, or teamwork, such as conflict management and communication skills (Senior and Swailes, 2007; Stevens and Campion, 1994). Team level inputs in the literature include constructs such as team composition (Edmondson, 1999; Cohen and Bailey, 1997), development of a purpose (Mickan and Rodger, 2005; Edmondson, 1999; Porter-O'Grady, 2015) and power or autonomy (Payne et al., 2009; Aime et al., 2014). The approach to understanding context as an input focuses mostly on resources available at the organizational level such as, availability of suitable information from varying sources and perspectives, time to work on team activities and provision of incentives (Payne et al., 2009; Senior and Swailes, 2007). While the importance of the external context has been noted by team researchers more broadly (Payne et al., 2009; Mathieu et al., 2008; Cohen and Bailey, 1997) its articulation in team effectiveness models is not always apparent.

Many team effectiveness input constructs were found in the review of the healthcare governance literature. Low levels of formal training in technical skills of quality improvement have been found at the board level (see, for example (Jha and Epstein, 2010; Jiang et al., 2008),). The Keogh review of low performing NHS trusts identified limited available skills in data analysis as a barrier to governance oversight (Keogh, 2013). Technical knowledge and skills have been shown to have a positive impact on board effectiveness (Payne et al., 2009). In clinical teams, technical KSAs are monitored through systems of credentialling or developed through ongoing mandatory professional development schemes. Conflict management, leadership and effective communication are teamwork KSAs identified in the broader governance literature (Buechner et al., 2014; Freeman et al., 2016; Gautam, 2005). The existence of, or development of, teamwork KSAs that support effective governance have received little attention in healthcare literature to date.

Governance research has historically had a strong focus on the structure and composition of boards, which aligns with team level inputs. Board composition research has failed to convincingly find a strong association between structural factors such as size, demographics, diversity and tenure of members, and financial performance (Chambers et al., 2013; Nicholson and Kiel, 2007). Edwards and Clough (2005) suggest that structural factors may be important in providing the right environment or minimum standards for governance, but are not in themselves sufficient for good performance. Others argue that the influence of structural inputs may be context specific (Chambers, 2012), for example, board clinical representation can influence quality of care (Prybil, 2006; Jiang et al., 2009). A more recent study found this to be the case, only when combined with other organizational-related structural input factors such as organizational autonomy (Veronesi et al., 2015).

Inputs articulated in team literature move beyond structural considerations, to an exploration of factors not readily addressed in the healthcare governance literature. A team needs a clear purpose which can drive development of specific objectives (West, 2012). While there has been a considerable focus in healthcare governance research on activities of the board, there is little understanding of the clarity of purpose behind these activities.

The healthcare governance literature has touched on organizational-level inputs through examination of information made available to the board to perform its duties (see for example (Jha and Epstein, 2013; Jiang et al., 2009; Mannion et al., 2015)). However, broader external influences on healthcare governance effectiveness need further investigation. The influence of external factors on healthcare governance can be seen both in the existence of other forms of governance and in variations in corporate governance structures that exist in public healthcare in countries such as the UK, USA, Australia and NZ. These countries vary in the number of executives included as formal board members, which may have implications for the way in which boards relate to, and work with, their management team. The clarity with which the board's role in governing healthcare quality is expressed in legislation and regulatory mechanisms may also influence understanding of purpose and role perceptions at the board. The external context as an input has been added to the healthcare governance framework to reflect the influence of the broader social and political environment at this level of governance.

A summary of key inputs arising in the team literature and the volume of papers from the healthcare governance literature review that address each construct is presented in Table 2.

2.2. Mediators

In early conceptualisations of team theory, mediating processes were described as comprising taskwork and teamwork processes (Mathieu et al., 2008). Taskwork describes the actions a team must undertake to achieve team tasks, 'the what', and teamwork describes the interactions between team members, 'the how' (Marks et al., 2001). Teamwork is seen as guiding the execution of taskwork through 'direct (ing), align(ing) and monitor(ing) taskwork' (p. 357) (Marks et al., 2001). Yet, much contemporary team literature and conceptual models, such as the IMOI model, are focussed on teamwork processes with less analysis of the concept of taskwork. This may be because taskwork is varied and specific according to the team and context under study.

2.2.1. Teamwork mediators

According to the IMOI model, understanding teamwork requires consideration of both behavioural processes and emergent states. Analysing behavioural processes, the actions or interactions between team members, involves concepts such as leadership, decision-making, communication and conflict management (Marks et al., 2001). The influence of emergent states on governance effectiveness requires exploration of attitudes, motivations or thought processes. Emergent states can be either affective, such as developing trust, cohesion and conflict, or cognitive such as developing shared role understanding and

Table 2
Key input constructs in the healthcare governance literature review.

Input Level	Construct in the healthcare governance literature	Volume of papers with construct in literature reviewed
Individual	Technical knowledge skills and abilities (quality improvement and data analysis) (Governance Institute of Australia, 2016; Dickinson and O'Flynn, 2016; Buechner et al., 2014; Freeman et al., 2016; Millar et al., 2015; Chambers et al., 2013; Cornforth, 2012; Millar et al., 2013; Department of Health, 2000; Kohn et al., 2000)	+ + +
	Teamwork knowledge skills and abilities	+
Team/Corporate Governance	Board composition (Wilson et al., 1995; Wilson and Van Der Weyden, 2005; Klaidman, 2007; Walshe and Shortell, 2004; Francis, 2013a; Hindle et al., 2006)	+ + +
	Defined Purpose (Millar et al., 2013; Botje et al., 2013)	+
	Power/Autonomy (Condition of participation, Quality Care Commission, 2014; National Quality Board, 2013)	+ +
Organization	Resources (financial, technical, material) (Governance Institute of Australia, 2016; Prybil, 2006; Veronesi et al., 2013)	+ +
	Information/Data available (Governance Institute of Australia, 2016; Freeman et al., 2016; Chambers et al., 2013; Cornforth, 2012; Millar et al., 2013; Kohn et al., 2000; Klaidman, 2007; Prybil, 2006; Veronesi et al., 2015; Bismark et al., 2013; Jha and Epstein, 2010; Jiang et al., 2012; Jha and Epstein, 2013; Jiang et al., 2008; Jiang et al., 2009)	+ + +
External	Legislation and regulation (Veronesi et al., 2015; Jiang et al., 2012; Jha and Epstein, 2013)	+ +
	Accreditation (Governance Institute of Australia, 2016; Freeman et al., 2016; Klaidman, 2007; Prybil, 2006; Veronesi et al., 2015; Jiang et al., 2012; Prybil et al., 2010)	+ + +
	Socio-cultural influences	+

+ + + Considerable volume of literature (more than 6 peer reviewed papers).
+ + Several journal articles (3 or more peer reviewed papers).
+ Little or no known literature.

goals (Marks et al., 2001; Mickan and Rodger, 2005; Jelphs and Dickinson, 2008; Millward and Jeffries, 2001; Strating and Nieboer, 2009). These last two mediators are particularly important in work that is comprised of more cognitive tasks, such as governance, which involve planning, design and decision-making (Cooke et al., 2000). Recent healthcare governance literature illustrates these teamwork mediators. Freeman et al. (2016), found through measures of engagement used in previous international research that boards that appeared to be highly engaged with quality had considerable differences in the way analysis of poor performance was framed. The authors found that data on poor performance was either framed as unreliable data, associated with an unreasonable target or an event requiring investigation. Similarly, Keogh's (Keogh, 2013) review of low performing NHS trusts identified the tendency to use information for justification, rather than for enquiring into areas of concern.

The framing of a quality issue is an aspect of communication and appears to be an important behavioural process influencing healthcare governance effectiveness and may reflect the level of trust that exists. A key task in healthcare governance is for management to reveal operational areas that require improvement. The need for high levels of trust, an affective state, between board and management to enable full and open discussion regarding quality issues has been highlighted in the recent healthcare governance literature (Millar et al., 2015; Chambers, 2012). Reduced trust may lead individuals to resist any revelations that may be interpreted as weaknesses. These constructs influencing healthcare governance fit into behavioral processes and affective emergent states mediators suggested in team literature.

The degree to which board members and managers have developed a shared understanding of their respective roles and their shared work objectives has received little attention in the healthcare governance literature and may be an important cognitive mediator of effectiveness.

2.2.2. Taskwork mediators

The IMOI model does not address activities and tasks of teams as a mediating process. Evidence presented earlier demonstrated variable board engagement in healthcare governance tasks and provided evidence that governance taskwork is positively associated with healthcare outcomes. Engagement in taskwork is an important mediating influence of healthcare governance effectiveness.

Adding taskwork as a mediator of governance effectiveness in the conceptual framework requires examination of detailed processes related to each key healthcare quality task. Much of the empirical literature examining key tasks in governing healthcare quality have used broad measures of taskwork to study board engagement. The task of monitoring quality performance is often presented as a survey question probing the use of quality dashboards or scorecards (Jha and Epstein, 2010; Vaughn et al., 2006). Yet it is clear there is more to monitoring quality performance. The Francis report arising from the enquiry at Mid-Staffordshire Hospital makes clear the distinction between having performance data available and translating this data into knowledge that supports a clear understanding. Report recommendations include the need for appropriate performance metrics with norms established to allow identification of poor performance (Francis, 2013b).

The task of monitoring quality of care performance can, for example, be broken down into key mediating processes such as:

- Developing an agreed measurable definition of healthcare quality (Hundert and Topp, 2003; Heenan et al., 2010).
- Board endorsement of quality measures (Prybil et al., 2010, 2014; Kroch et al., 2006)
- Developing a quality reporting framework with agreement on format, frequency and reporting responsibilities (Jha and Epstein, 2010; Jiang et al., 2008; Vaughn et al., 2006; Baker et al., 2010; Levey et al., 2007).
- Regular reporting of performance (Jha and Epstein, 2010; Jiang et al., 2012; Mannion et al., 2015; Prybil et al., 2008)
- Trending and benchmarking performance (Jha and Epstein, 2010; Jiang et al., 2009, 2012)
- Identification of areas for improvement with corrective action plans identifying responsibilities and timelines (Prybil et al., 2010; Kroch et al., 2006)
- Reporting on progress of corrective actions in relation to serious issues and incidents (Jiang et al., 2008; Baker et al., 2010)
- Periodic review of quality monitoring framework (Australian Commission on Safety and Quality in Health Care, 2011; Joshi and Hines, 2006)

In this way, a detailed examination can be made of the extent to which all the processes related to each key task in governing healthcare quality are undertaken. Key tasks, in addition to performance

Table 3
Key mediator constructs in the healthcare governance literature review.

Category of Mediator	Construct in the healthcare governance literature	Volume of papers with construct in literature reviewed
Taskwork	Monitoring quality performance (Governance Institute of Australia, 2016; Buechner et al., 2014; Freeman et al., 2016; Klaidman, 2007; Jiang et al., 2009; Prybil et al., 2010; Vaughn et al., 2006; Nicholson and Kiel, 2007; Weiner et al., 1996; Botje et al., 2014; Tsai et al., 2015; Chambers et al., 2012; Cornforth, 2001; Murray, 2004; Nuckols et al., 2013)	+ + +
	Developing quality priorities (Jiang et al., 2008; Jiang et al., 2009; Prybil et al., 2010; Nicholson and Kiel, 2007; Tsai et al., 2015; Weiner et al., 1997; Braithwaite and Travaglia, 2008; Brook et al., 1996; Duckett, 2016; Lilford et al., 2004; Pronovost and Lilford, 2011)	+ +
	Leading and promoting a quality culture	(not mapped)
	Resourcing and oversight of key quality systems	(not mapped)
Teamwork: Behavioural processes	Leadership (Wendt et al., 2009; Conger and Lawler, 2009; Forbes and Milliken, 1999)	+ +
	Communication (National Quality Board, 2013; Veronesi et al., 2013; Jiang et al., 2012; Wendt et al., 2009; Kay and Goldspink, 2015)	+ +
	Decision-making (Hindle et al., 2006; Quality Care Commission, 2014; Wendt et al., 2009)	+ +
Teamwork: Affective emergent states	Trust (Governance Institute of Australia, 2016; Cornforth, 2012; Kohn et al., 2000; Botje et al., 2013; Quality Care Commission, 2014; Wendt et al., 2009)	+ + + +
	Respect:	+
	Cohesion:	+
	Conflict (National Quality Board, 2013)	+
Teamwork: Cognitive Emergent States	Shared role understanding/Role clarity (Payne et al., 2009; Molinari et al., 1993; Evans et al., 2011; Valentine et al., 2015)	+ +
	Shared objectives/goals (Jiang et al., 2009)	+
Teamwork: other descriptions	Social Dynamics (Governance Institute of Australia, 2016; Cornforth, 2012; Millar et al., 2013; Hindle et al., 2006; Kay and Goldspink, 2015):	+ +

+ + + Considerable volume of literature (more than 6 peer reviewed papers).
+ + Several journal articles (3 or more peer reviewed papers).
+ Little or no known literature.

monitoring, include oversight of quality strategy and planning (Jha and Epstein, 2010; Vaughn et al., 2006; Mannion et al., 2015; Baker et al., 2000), leadership by promotion of a quality culture (Conway, 2008; Weiner et al., 1997)and the resourcing and oversight of key quality systems such as credentialing and incident management (Braithwaite and Travaglia, 2008).

Adding the taskwork category to the proposed framework, reflecting current evidence in the healthcare governance literature, provides a comprehensive basis for exploring interactions of inputs, taskwork and teamwork mediators on governance effectiveness. Table 3 below maps the volume of papers in which mediator constructs in team theory were found in healthcare governance literature. Note that only two of the four identified tasks of governance of healthcare quality were included in the mapping exercise.

2.3. Outputs

The team effectiveness literature outlines individual, team and organizational levels at which outputs and outcomes can be assessed. Individual-level outputs may be evaluated, for example, through role-based performance measures (Mathieu et al., 2008). Team-level outputs can be assessed through subjective measures of the working relationship or, objective measures of sick leave, turnover or production measures (Kay and Goldspink, 2015; Cohen and Bailey, 1997). Organizational-level evaluation is considered most relevant to teams senior in the hierarchy where there is believed to be a closer alignment between work at this level and organizational outcomes (Mathieu et al., 2008; Lemieux-Charles and McGuire, 2006).

Research evaluating healthcare governance has focussed on organizational outcomes measured through patient, financial and efficiency outcomes measures. However, there are often challenges in identifying an appropriate mix of robust organizational-level measures that reflect the complexity of quality outcomes in hospitals (Adair et al., 2006; Brook et al., 1996; Duckett, 2016). Commonly used outcome measures, such as standardised mortality measures and infection rate, are plagued by methodological issues that weaken their usefulness (Lilford et al., 2004; Pronovost and Lilford, 2011; Scobie et al., 2006; Evans et al., 2011). Quality of care outcome measures are distant from governance activities and may be confounded by management practices and human resources issues such as workforce shortages. While patient outcomes are of ultimate interest in any strategy to improve quality, the team literature suggests additional measures that may overcome issues of access to suitable organisational-level outcome measures and their related attribution issues. The suggestion here is not to abandon outcome measures, but to also use these additional measures to obtain a more sensitive reading about performance.

The team effectiveness literature draws attention to individual- and team-level outputs as more proximal measure of effectiveness. Measures of teamwork quality at the governance level could be made through modifying existing team effectiveness tools that examine various teamwork constructs (Valentine et al., 2015). Measures of taskwork quality could be developed based on assessment of the presence or absence of processes related to each key governance quality task as outlined earlier. Evaluating team level healthcare governance outcomes, could then be obtained through developing a survey of teamwork and taskwork quality. An instrument such as this could be useful both for board evaluation and education purposes and for research in examining the relationship between various healthcare governance performance constructs and proximal outcomes. The team literature provides a useful basis for broadening the approach to evaluating outputs in healthcare governance.

3. The Healthcare Governance Performance Framework

The mapping process suggests several key constructs in the IMOI model are not yet fully explored in the healthcare governance literature. This exercise also highlights modifications required to construct categories for use in a healthcare governance framework. The resulting conceptual framework, the Healthcare Governance Performance Framework, is presented in Table 4.

The emphasis placed on broader socio-cultural influences as key inputs and the addition of taskwork mediators in the HGPF reflects evidence in healthcare literature of challenges and barriers particular to healthcare governance. The focus on board composition in the

Table 4
The healthcare governance performance framework.

Inputs	Mediators	Outcomes
Individual level • Technical knowledge, skills and abilities (quality improvement and data analysis) • Teamwork knowledge, skills and abilities **Corporate governance/board level** • Board composition • Defined Purpose • Power/Autonomy **Organization level** • Resources (financial, technical, material) • Information/Data available **External Level** • Legislation and Regulation • Accreditation • Socio-cultural influences	**Taskwork** • Monitoring quality performance • Oversight of quality priorities • Leading and promoting a quality culture • Resourcing and oversight of key quality systems **Teamwork** Behavioural processes • Leadership • Communication • Decision-making Affective emergent states • Trust • Respect • Cohesion • Conflict Cognitive Emergent States • Shared role understanding • Role Clarity • Shared objectives/goals	**Individual level** • Hospital director effectiveness **Team Level** • Quality of taskwork • Quality of teamwork • Hospital board effectiveness **Organizational level** • Quality and safety performance

governance literature as a key input to effectiveness is reflected in the healthcare governance literature reviewed, as shown in Table 2. The importance of individual quality skills and knowledge as a key input is also well established in the healthcare governance literature (see for example (Jha and Epstein, 2010; Jiang et al., 2008; Payne et al., 2009)) but considered mainly in terms of board members and not in relation to senior management who work closely with the board on governance tasks. Other inputs that are relevant to defined groups of people working together on common tasks such as a clear purpose and availability of resources and information to support the work are less well researched in healthcare governance (Chambers et al., 2013; Millar et al., 2013; Baker et al., 2010; Bismark and Studdert, 2014). External influences on healthcare governance are addressed in the literature in a limited way, mainly through the lens of accreditation (see for example (Baker et al., 2010; Bismark and Studdert, 2014)) and to a lesser degree legislation and regulations (Belmont et al., 2011; Goeschel et al., 2010). The broader social, political and cultural influences on healthcare governance need closer consideration in future research.

The overwhelming body of healthcare quality governance research is focussed on board engagement with quality tasks that are broadly described in surveys. This paper argues for a more detailed exploration of taskwork through exploring the extent to which processes related to each key quality task are undertaken. Such an approach would allow a nuanced understanding of the extent of board and management engagement in quality activities. Factors influencing engagement in quality taskwork can then be addressed through exploring input and teamwork mediating constructs in the HGPF.

Emerging research addresses teamwork constructs, either broadly under the heading of board dynamics (see for example (Veronesi et al., 2015; Baker et al., 2010)) or through specific enquiry into constructs such as trust (Buechner et al., 2014; Chambers et al., 2013) or communication (Freeman et al., 2016; Gautam, 2005). The mapping in Table 3 highlights teamwork constructs currently under researched in the healthcare governance setting include behavioural constructs such as leadership and decision making, affective constructs such as cohesion, conflict and respect and cognitive constructs such as shared role understanding and shared objectives.

The HGPF will assist in guiding a theory-led approach to generating research questions and in investigating factors previously under researched which may influence healthcare governance. The framework can be used to provide clear categories and constructs against which case studies can be assessed in a systematic way. Future research can also test the extent to which relationships between construct categories outlined in the IMOI model are evident in healthcare. The HGPF could also be used to develop a survey tool, as discussed earlier. Once validated, a survey tool could be used in research to understand the relative contribution of different constructs to healthcare governance effectiveness through factor analysis. A survey tool could also have practical applications in informing governance assessment processes and fostering a multifaceted approach to ongoing development of board and management.

One limitation of our framework is that most of the healthcare governance literature reviewed was undertaken in the acute hospital setting. The applicability of the framework to other healthcare settings, such as primary care organisations with boards, is an area for future research. Refinements to the framework may also be needed as any future empirical work brings greater understanding of constructs previously under researched in healthcare.

4. Conclusions

This paper has presented a theoretical argument for developing a conceptual framework relevant to healthcare governance to guide further investigation of the working relationship of managers and boards in governing healthcare quality. Mapping key constructs in team literature to the occurrence of these constructs in healthcare governance literature, produced compelling evidence of the relevance of many of the constructs and categorizations in team literature to the healthcare governance setting. This in turn provided the theoretical justification for using the IMOI model as a starting point for developing a conceptual framework, the Healthcare Governance Performance Framework (HGPF).

By giving order to key constructs in a conceptual framework, this paper provides a new approach to examining factors that influence healthcare quality governance. The paper also highlights the need to consider these factors not only in relation to board members but also to senior managers who work with boards.

The HGPF makes visible multiple factors at play in the relationship between governance and healthcare quality. It promotes a nuanced understanding of the complexities of governance and helps explain why boards sometime struggle to engage with their clinical governance responsibilities.

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