Communication and leadership in healthcare quality governance

Findings from comparative case studies of eight public hospitals in Australia

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Abstract

Purpose – The importance of hospital board engagement in the work of governing healthcare quality has been demonstrated in the literature. Research into influences on effective corporate governance has traditionally focused on board architecture. Emerging research is bringing to light the importance of governance dynamics. This paper contributes to emerging research through highlighting how communication and leadership underpin effective engagement in governing healthcare quality.

Design/methodology/approach – A comparative case study of eight Australian public hospitals was undertaken involving document review, interviews and observations. Case studies were allocated into high- or low-engagement categories based on evidence of governance processes being undertaken, in order to compare and contrast influencing factors. Thematic analysis was undertaken to explore how communication and leadership influence healthcare governance.

Findings – Several key components of communication and leadership are shown to influence healthcare quality governance. Clear logical narratives in reporting, open communication, effective questioning and challenge from board members are important elements of communication found to influence engagement. Leadership that has a focus on healthcare excellence and quality improvement are aligned and promote effective meeting processes is also found to foster governance engagement. Effective engagement in these communication and leadership processes facilitate valuable reflexivity at the governance level.

Practical implications – The findings highlight the way in which boards and senior managers can strengthen governance effectiveness through attention to key aspects of communication and leadership.

Originality/value – The case study approach allows the exploration of communication and leadership in greater depth than previously undertaken at the corporate governance level in the healthcare setting.

Keywords Governance, Leadership, Communication, Healthcare, Clinical governance, Quality healthcare

Paper type Research paper

Introduction

Factors influencing effective corporate governance of healthcare quality have increasingly come under scrutiny as a board’s role in ensuring better patient outcomes is made explicit in legislation and regulations (see, e.g. Belmont et al., 2011; Care Quality Commission, 2014). Research demonstrates that governance engagement in healthcare quality activities varies (Bismark and Studdert, 2014; Baker et al., 2010; Prybil et al., 2010), and a small but significant association between engagement and healthcare outcomes exists (Jha and Epstein, 2010; Jiang et al., 2009; Vaughn et al., 2006). However, little is understood as to why engagement varies.

While evidence, in governance literature, on the influence of structural factors, such as board size and composition, on performance is unconvincing and contradictory (Chambers et al., 2013; Cornforth, 2001; Dalton et al., 1998; Roberts et al., 2005), there is growing evidence of the importance of healthcare governance skills. Significant associations between numbers...

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of clinician board members and hospital performance in processes and outcomes of care (Jiang et al., 2009), ratings of quality (Veronesi et al., 2013) and patient experience ratings (Veronesi et al., 2015) have been identified. Higher ratings of board member quality skills and competencies are positively associated with staff attitudes to quality (Mannion et al., 2017), outcomes of care (Jha and Epstein, 2010) and hospital clinical quality performance (Jha and Epstein, 2013).

While healthcare skills are structural factors that appear relevant in healthcare, increasingly there are calls for a greater focus on complex mediating factors that influence governance effectiveness (Bennington, 2010; Chambers et al., 2013; Cornforth, 2012; Edwards and Clough, 2005; Pettigrew, 1992; Pye and Pettigrew, 2005; Roberts et al., 2005). Limited understanding of board internal processes and dynamics has been described as the ‘black box’ of governance (Pettigrew, 1992, p. 178). This paper contributes to emerging research, exploring the internal workings of corporate governance, through examining how key elements of communication and leadership influence healthcare governance engagement. This is explored through a comparative case study of eight Australian public hospitals undertaken through document review, interviews and observations.

This paper first describes emerging research that is beginning to illuminate the black box of governance. The approach taken in this study to explore and build on emerging research is then outlined. Elements of communication and leadership found to influence governance engagement in healthcare quality activities are then described. These factors influence how governance is enacted, and this in turn determines whether governance responsibilities are effectively addressed. This has practical implications for healthcare boards and managers in how they approach strengthening governance at their health services.

**Background**

The work of governance involves planning, analysing and decision-making. While the importance of communication in governance work is widely acknowledged (see, e.g. Cornforth, 2001; Erakovic and Overall, 2010), there is little close examination of communication processes in healthcare governance. Communication is generally referred to in broad terms such as ‘effective communication processes’ (Vaughn et al., 2014, p. 114) or ‘communication style’ (Buechner et al., 2014, p. 307).

Leadership, while subject to multiple interpretations, has been defined as the ‘process of influencing the activities of an individual or group in efforts towards goal accomplishment’ (Hersey et al., 1979, p. 418). Corporate governance leadership can be viewed either as the strategic leadership provided by board to the organisation (Chait et al., 2005), or leadership to ensure the ‘constructive involvement’ (Huse et al., 2008, p. 527) of participants in corporate governance activities. In the former, the governing body is important in setting the tone (Millar et al., 2015), being visible (Gautam, 2005) and committed to improving healthcare quality (Millar et al., 2013). However, the latter conceptualisation is of interest in this paper and has received less attention. The focus is on leadership that ensures the effective participation of senior managers and board members in healthcare quality governance activities.

Limited understanding of communication and leadership processes in healthcare governance reflects a general lack of understanding of the internal workings of governance (Erakovic and Overall, 2010). Emerging research is illuminating processes and subtle dynamics between board members and senior managers in the conduct of healthcare governance. In detailed case studies of four UK NHS boards, Freeman et al. (2016) found differences in the framing of management reporting on infection control data. The authors found data on poor performance was either framed as unreliable data associated with an unreasonable target or an event requiring investigation. The authors warn that communication practices such as framing can act to diminish the governance response to data indicating potential problems.
Jones et al. (2017) in a multiple case study of 15 UK healthcare organisations found differences in the characteristics of boards more engaged in healthcare governance processes. Higher-engaged boards were found to prioritise quality improvement, invest in long-term quality priorities, use data for improvement, engage broadly with staff and patients and have effective clinical board members (Jones et al., 2017). Emerging research demonstrates that qualitative methods can bring a more nuanced understanding of influences on governance.

Methods
The internal workings of healthcare governance are examined through a comparative case study of eight Australian public hospitals. Multiple case studies allow cross-case comparison of similarities and differences to identify patterns that can support or contradict a theoretical proposition (Eisenhardt, 2002; Stewart, 2012).

Sampling
Corporate governance arrangements in Australian public hospitals vary reflecting both legacy arrangements and state-level negotiated agreements and legislation. Public hospitals are governed by boards in most, but not all, Australian jurisdictions. Boards typically consist of between 7 and 10 non-executive members and are accountable to the health minister in their jurisdiction. In NSW, membership also includes hospital clinician representation.

Boards with direct responsibility for governing healthcare quality occurred in sufficient numbers in three states of Australia. Six Victorian and two New South Wales (NSW) case studies were selected. The NSW case studies were included to compare state-level contextual factor operating on corporate governance.

Victorian public hospitals were first stratified according to size and location. Hospitals that satisfied size and geographical requirements for selection were then stratified according to their perceived healthcare quality performance. Three experts in understanding healthcare quality delivered by Victorian public hospitals were identified and asked to nominate hospitals with high and low performance in healthcare quality. Expert opinion rather than data was used as there is a paucity of data that informs the evaluation and comparison of healthcare quality in Australia. A sub-population of Victorian hospitals, varying in size, location and perceived quality performance, was identified from which recruitment could commence. Two NSW case studies were sampled from a pool of NSW hospital networks of similar size to get one urban and one regional hospital. Letters were sent to hospital CEOs seeking involvement in this study. The final sample was made up of four large multi-campus health services, two medium-sized (sub-regional) rural health services and two small rural services.

Data collection and analysis
Case studies can employ multiple research methods which enable exposure to varied perspectives and provide rich and comprehensive data (Lauckner, 2012). Data in the form of interviews, document review and an observation of the board quality committee was collected at each site from July 2016 to April 2017.

Interviews allow participants freedom to express their experience without the 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). Interviews were sought with the CEO, board quality committee chair, senior staff member with designated responsibility for healthcare quality and two additional members of the board quality committee, comprising one board member and one senior manager. Semi-structured interviews were held with 39 participants comprising 7 CEOs, 15 board
members and 17 senior managers. Questions on the interview schedule explored board quality committee processes and characteristics of leadership and communication.

Interviews were transcribed and imported into NVivo where template analysis, a form of thematic analysis, was used to code transcripts. In template analysis, a codebook is developed to guide the categorisation of text (King, 2004). In this study, a codebook was developed prior to data collection from a previously developed conceptual framework (Brown et al., 2018). The codebook was refined after reviewing the first three interviews. All interviews were then analysed deductively with the revised codebook in line with practice for template analysis (Brooks et al., 2015). A secondary inductive and iterative analysis was applied to identify emergent themes.

Documentary review is important in gathering comprehensive information that is not readily available by other methods (Bowen, 2009). Twelve months’ worth of board quality committee papers, terms of reference and planning documents formed the document review. A systematic process of reviewing the large volume of governance papers was undertaken (Bowen, 2009). Systematic document review provided accurate and detailed information regarding governance data reporting and processes over an annual cycle. This approach was necessary as interviewees’ historical recall of data reported and processes undertaken was variable and at times limited. Information on internal governance processes was summarised in a word template.

Observations were included as the observer may see things participants may not be aware of (Patton, 2002). Observations also provide a detailed view of meeting practices and dynamics in ‘real time’ (Yin, 2009) that cannot be fully captured by minutes or second-hand descriptions. One board quality committee meeting was observed at each case study. The board quality committee was the site of observation as this is where most corporate governance of healthcare quality occurs (Jones et al., 2017). Observation notes were taken by a single doctoral researcher noting meeting processes, questions raised, discussions by whom and for how long and the nature of interactions between participants.

After the three data sources had undergone separate initial thematic analysis, a further thematic review was undertaken on the entire data set to explore influences on governance engagement. Case studies were allocated into high- or low-engagement categories. Engagement status was determined through reviewing a list of 40 key processes developed previously, related to two key tasks of healthcare governance, evaluating healthcare quality and overseeing quality priorities (Brown, 2019). A point was assigned for each process undertaken. High or low engagement levels were allocated to case studies based on the sum of engagement points. The distribution of case studies into high- and low-engagement categories is shown in Table I. Case studies are indicated by the nomenclature ‘C’ with C1 representing the highest engaged case.

<table>
<thead>
<tr>
<th>High engagement score (21–40)</th>
<th>Low engagement score (1–20)</th>
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<tbody>
<tr>
<td>C1 (34)</td>
<td>C5 (19)</td>
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<td>C2 (29)</td>
<td>C6 (19)</td>
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<td>C3 (25)</td>
<td>C7 (16)</td>
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<td>C4 (25)</td>
<td>C8 (15)</td>
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Table I. Engagement levels
engagement were compared to identify patterns of similarities and differences in factors related to communication and leadership.

Results
This section outlines how communication and leadership influence healthcare governance. It begins with a description of board quality committee meetings at C1 and C8, reflecting high- and low-engagement case studies, respectively, to highlight the contrasting approaches to communication and leadership. This is followed with a detailed exploration of elements of communication and leadership found to be important, through the analysis of all case studies. Together, effective communication and leadership processes foster reflexivity which is important in continuously improving healthcare quality governance practices.

Board quality committee observations
C1 is a large hospital network located in Victoria with the highest engagement score. The chair commenced the board quality committee meeting seeking questions on agenda items marked for noting. The meeting was characterised by frequent questions by board members. An agenda item on serious clinical incidents was accompanied by a summary document in meeting papers, outlining trends and types of incidents, high-level summaries of each incident and action undertaken. The chair assumed this had been read and time spent on this item largely involved questions by board members 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 at the next meeting.

Half the meeting was devoted to consideration of clinical risk. In a presentation, a clinical manager clearly outlined background information about the impact, current management and organisation-wide issues related to pressure injury management. The manager in discussing issues remarked ‘our risk is significant’ and ‘we’ve exceeded the target in the negative sense, so we have got some work to do’. 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.

C8 is a small rural hospital located in Victoria and received the lowest engagement score. Discussion of three serious clinical incidents took over half the meeting. Summary incident information was not available in board quality committee meeting papers. The Director of Medical Services (DMS) gave detailed information about symptoms, investigations, medication and the sequence of events for each patient. This involved technical language, for example, in reading out imaging results. A clinical background board member, along with clinical managers, was drawn into discussion of individual patient management. Two non-clinical board members remained silent during this long 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 identified nor followed up by the chair.

A board member’s question about a red flag on a falls assessment screening audit elicited a senior manager’s 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 audit methodology. A staff member suggested a review of methods, the chair agreed but no definitive action or reporting back was identified. During the meeting the chair introduced new agenda items and asked for questions. Summaries of C1 and C8 are provided in Table II.

Different approaches to communication and leadership are evident in these descriptions. The C1 meeting was organised to promote discussion and debate through providing reports and presentations structured to highlight system-level issues and chairing that facilitated
engagement. Verbal provision of technical information at C8 took much of the short meeting time, leaving little time or encouragement of discussion.

**Communication**

Influential aspects of communication, found in high-engagement cast studies, include clear logical narrative reporting, open communication, effective board questioning and challenge.

**Clear logical narrative.** Managers presenting a clear logical narrative when reporting on complex healthcare quality issues was found to be important. Board members have intermittent exposure to quality issues through meetings and grapple to understand large volumes of complex information in meeting papers. A board member describes this as being ‘swamped with paperwork . . . and it’s hard to see the wood from the trees’ (board quality committee chair, C2). Board members encounter a ‘vastly different language’ which compounds an ‘information asymmetry’ (board member, C1) between managers and board and is a barrier to understanding. The way information is conveyed is therefore important in quick orientation to and understanding of issues. At the three highest-engaged case studies, managers had a key role in preparing verbal and written reports that were concise and used non-technical language to present a clear, logical narrative. A manager describes a presentation on a clinical risk,
Much of this is sort of stories . . . can you prevent suicide [in the psychiatric service]? What, do we know about suicide and our ability to influence that. So, we had to get an evidence base and then we had . . . to tell the story of the evidence base . . . and then say well this is how we’re going in relation to that. (quality director, C1)

Managers have a key role in ensuring effective communication of complex information ‘they’re there to make the connections, they are there to tell the story’ (board quality committee chair, C1). Developing a clear narrative to foster board understanding requires a ‘greater rigour in language and explanation’ (CEO, C3) from managers than needed at an operational level.

C8, the lowest-engagement case study, provided detailed technical information in verbal reports at the board quality committee. Information was not tailored to provide a high-level narrative overview of issues appropriate to governance oversight responsibilities. Reflecting on the effect of this the CEO said,

We’re our own worst enemy. We take . . . board members to a subcommittee meeting . . . feed 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. (CEO, C8)

Careful management preparation of board information through a clear, logical narrative facilitates understanding of system issues and fosters board engagement in constructive discussion and debate.

Open communication. Open communication is defined, in this study, as the ability of governance participants to freely share and receive information and thoughts. Open communication was found to be an important influence on engagement. One aspect of open communication is managers providing an unfiltered range of healthcare quality data to enable a board to make a balanced assessment of an organisation’s status. This was evident in high-engagement case studies with board member and manager interviewees consistently articulating a commitment to transparency. At C1, board members saw the provision of healthcare quality information to be ‘it’s warts and all’ (board quality committee chair, C1) and ‘the board is in lock step, we know as much as managers know’ (board member, C1). This is reflected in the CEO’s comments,

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 . . . this is how we’re trying to get there. (CEO, C1)

An improvement focus rather than a blame culture is seen as crucial to transparent manager communication, ‘let’s treat it [underperformance] as an opportunity rather than a criticism’ (board chair, C4). This improvement focus is mentioned frequently by interviewees at high-engagement case studies.

The culture . . . within the [board] attendees of the [Board quality committee meeting] is really about “We’re here to support you to realise what we want you to realize” rather than being, they can judge, they can make an assessment as to whether it’s not [optimal performance]. But it’s in the improvement and delivery of success rather than acknowledging failure. (CEO, C1)

This contrasts with information gatekeeping in a case study where a strained relationship existed between the former chair and executive and resulted in reduced manager openness.

We never used to filter for what went through . . . all of a sudden . . . “ [the CEO said] “no, you can’t, that’s [information] not going. (quality manager, C4)

Framing communication, the process of developing a particular perspective on an issue (Chong and Druckman, 2007) was observed in case studies to either highlight issues needing attention or in casting doubt on data reliability. In several case studies, managers deliberately framed data to promote uneasiness with the healthcare quality status. At C1, managers
highlighted pressure injury risks, as described in the meeting observation. Opportunities were also created in several case studies to remind board members of harm inherent in healthcare through case presentation of serious incidents, walkarounds and discussion of emerging clinical risks. As this CEO describes,

We’re in a dangerous business. We are harming patients. Even on a good day we’re harming people... so I’ll have that conversation... all the time (CEO, C3).

This approach fosters governance vigilance and promotes open discussion and analysis of issues.

At C8, two examples of framing to cast doubt on data, highlighting potential issues with healthcare quality, were identified. At the board quality committee meeting, inadequate data collection methods were suggested, when a falls assessment screening audit highlighted compliance problems. In the second instance, a few board members framed a consultant’s recommendations on improvements to perioperative services as a problem with the conduct of the review. While open communication is often considered in terms of whether information provided by managers is transparent, C8 provides an example of unwelcome information that is actively resisted by some board members.

Open communication requires not only managers communicating a realistic view of healthcare quality but also careful consideration of information received. Board member receptivity to healthcare quality information and undertaking further exploration was aided by the framing of information to highlight risk.

**Effective questions and challenge.** Managers consistently expressed the desire for, and benefits of, effective board challenge. Effective challenge meant not only that managers like ‘be asked more questions’ (quality manager, C6), but they welcomed the board to be ‘searching in their questions’ (DMS, C1). Constructive board challenge lifted managers out of ‘what’s going on every day’ (CEO, C1) and encouraged a broader perspective. Effective board challenge forced managers ‘to think more about the data that’s been presented’ (quality manager, C6). This influenced future directions and actions as noted,

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. (CEO, C1)

Yet board members found it ‘hard to ask questions’ (board member, C3). Time was important in developing effective questioning skills, as explained,

[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. (board member, C5)

Effective challenge involved careful questioning of assumptions underlying data analysis and action taken. Simple questions such as ‘why is this happening’ and ‘have these actions been effective’ were instrumental in driving managers to reflect more deeply on data and consequently supported a greater rigour in the approach to healthcare improvement. Simplifying questions serves two key purposes. Firstly, simple questions drive greater appreciation of an organisation’s accountability to their community or a bringing ‘back to reality’ (DMS, C4) that managers are not exposed to in everyday work. 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. (board member, C3)

Questions are sometimes 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’ (board quality committee chair, C2). While managers welcome challenge from
board members, questions need to be framed respectfully. Questions ‘asked in an appropriate way’ (DMS, C3) acknowledge the actions and initiatives of staff and support a ‘subtle inquiry and subtle focus’ (CEO, C1).

Effective questioning is an important board skill yet is influenced by ‘having the confidence’ (board member, C1) to speak to managers and clinicians, particularly doctors. Case studies that actively promoted board members’ questions helped overcome this barrier. At C3, orientation included the following advice from senior managers to ‘please ask the question because if you’re thinking the question there might be two or three others who are thinking it also’. (board member, C3).

Board members effectively challenged managers through asking simple questions focusing on factors contributing to healthcare quality issues and the effectiveness of remedial actions. Questioning that takes this form implicitly acknowledges a manager’s expertise in responding to and implementing actions to address healthcare issues, while fostering a deeper discussion and reflection on contributing factors and the degree to which risk has been mitigated. Effective questioning was more evident in high-engagement case studies.

Leadership

Elements of leadership identified as important in influencing governance engagement in healthcare quality, in this study, include a focus on healthcare excellence and quality improvement, aligned leadership and effective meeting leadership.

Leadership focus. A key governance role in hospitals is ensuring a strong healthcare quality focus at the board table. However, healthcare quality is not a singular concept and was found in this study to embrace three possible foci; meeting healthcare quality compliance requirements, developing quality system maturity or pursuing organisational healthcare excellence. To some extent, these foci reflect different stages of organisational maturity; however, they also reflect different understandings of purpose. A focus on pursuing healthcare excellence was more evident in high-engagement case studies. Low-engagement case studies had a stronger focus on compliance obligations. Pursuing healthcare excellence was influential in fostering governance engagement in a broader range of healthcare quality activities.

At C1, a strong focus on pursuing excellent care beyond minimum accreditation standards existed, ‘the patient just comes first’ (board member, C1). In all high-engagement case studies, a healthcare excellence focus was accompanied by a strong quality improvement culture with open communication of issues by senior managers.

At C8, ‘the focus of the organisation was on just passing the accreditation’ (CEO, C8). This compliance focus was found in case studies preoccupied with finances. Three of the five lowest-engagement case studies were perceived to have a stronger focus on finance than quality due to recent financial pressures.

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? (quality manager, C5)

The challenge for leaders in these circumstances was to not lose sight of quality considerations, as explained, ‘maintain the focus on quality and safety. But... put a bit of urgency around rectifying... the financials’ (CEO, C4). Higher-engaged cases were able to address financial stresses without losing focus on pursuing healthcare excellence.

Aligned leadership. The CEO, board chair and quality committee chair were all identified, in this study, as influential leaders in governing healthcare quality. A CEO leads senior managers, and through their staff, and has the ultimate responsibility for decision-making at the operational level. The board chair is influential in guiding the whole board in their focus, activities and decision-making. Similarly, a committee chair leads the focus...
and activity of a board committee and can influence the degree to which a committee adds value to the board. This study found a shared vision for healthcare quality between CEO and board chair, or aligned leadership, influenced governance engagement in healthcare quality activities.

CEOs were found to be a major influence in promoting a governance focus on healthcare quality. Effective CEO leadership influenced the engagement of both board members and managers. A CEO pursuing a healthcare quality focus influenced others’ thinking, as explained ‘when the CEO walks and talks it… it models it for the rest of the organization’ (quality director, C1).

I think the chief exec has a lot to do with this… he can either be the person… 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… the CEO has had a very, very clear view of that himself. (board quality committee chair, C1)

The C8 CEO wanted to pursue a focus on improving quality systems, yet his leadership of this was ineffective as described,

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… I felt very on my own. (quality manager, C8)

Managers and board members in high-engagement case studies spoke consistently about the CEOs contribution in developing a clear, shared focus on healthcare excellence at the governance level.

A board chair’s influence in limiting or promoting a healthcare quality focus was evident. In a few case studies, a change in chair saw a fundamental shift in board focus, as explained.

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 (quality manager, C4)

The healthcare quality focus of a board quality committee chair was generally accepted; however, their influence was confined to the board quality committee and their ability to influence other board members and executives was mentioned less often than the board chair or CEO. At two cases, attempts to drive a stronger board quality focus saw the board quality committee chairing being undertaken by a board chair who was perceived to be more influential. This move was described as the need to ‘evolve a level of conversation, the complexity of conversation in safety and quality and clinical governance’. (board chair, C5).

A CEO and board chair sharing a healthcare quality focus influenced governance engagement. The C1, CEO, board chair, board quality committee chair and quality director all had a strong focus on healthcare excellence as explained.

[Board quality committee chair]… had an understanding, CEO was very clear, [board chair] was very clear. So, I think the people driving it… knew what was important. (board member, C1)

At three lower-engaged case studies (C4, C5, C8), champions for healthcare quality excellence were identified, in quality or senior clinical positions, but were not supported by board chair and/or CEO leadership. At C8, the board chair, who also chaired the board quality committee, had low quality experience. This was compounded by limited CEO influence which resulted in a compliance focus and left a board member feeling ‘we do have to get quality and safety front and centre’ (board member, C8).

Effective meeting leadership. Effective meeting leadership was found to be critical in fostering governance engagement in healthcare quality work but was less apparent in low-engagement case studies. Effective board quality committee leadership was evident in leaders who facilitated effective communication through overseeing committee papers,
agenda structure and controlling meeting discussions. An effective chair was crucial to
effective meeting leadership and greater involvement in governance tasks, as explained.

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 (CEO, C1)

our Board culture is … just interrupt everybody all the time … So, effective chairing is quite
important (board member, C8)

However, effective board quality committee meeting leadership was not just driven by the
committee chair. The convenor, usually the quality director or manager, could also be a
strong influence. In three of four high-engagement case studies, there was evidence of the
board quality committee chair working closely with, or being guided by, the convenor, to
shape the agenda and information presented, through discussions prior to the meeting.
Strong board quality committee leadership, via board quality committee chair and/or
convenor, promoted effective communication in ‘enabling that time for discussion and open
discussion’ (board member, C1). Time for discussion was created through leadership skills in
discriminating between ‘what don’t we need to discuss, it’s brief and efficient, and what do we
need to discuss’ (board member, C2).

Effective leaders were also found to have an important role in initiating committee
effectiveness reviews. Reviews assessed a committee’s efficacy in undertaking governance
activities and evaluating information that aligned with healthcare governance
responsibilities. Formal assessments of committee effectiveness occurred via surveys in
five case studies. In some case studies, this also included reviewing reporting via scrutiny of
dashboards, reporting frameworks or calendars. This contrasts with the remaining case
studies that relied solely on changes made though informal opportunistic discussion of
reporting. At C8, no formal review process was evident with reporting reflecting what had
‘historically been presented’ (CEO, C8). Formal review processes, where they occurred, were
largely instigated by staff convening board quality committee meetings.

A chair’s role, supported by a convenor, in ensuring meeting time is used efficiently to
encourage discussion and debate and in influencing information provision is vital in ensuring
board quality committees accomplish their purpose.

Reflexivity
Reflexivity has been defined in team literature as the extent to which participants reflect upon
group objectives, strategies and processes and then adapt (Widmer et al., 2009). Reflexivity
emerged as an important influence on engagement in this study. Reflexivity was found in
case studies where both effective processes of communication and leadership existed as
shown in Figure 1. Reflexivity was fostered through effective communication processes,
which in turn were facilitated through effective meeting leadership.

Reflexivity operated in two main ways in case studies: through processes promoting
greater interrogation of data and actions and processes of reviewing governance
effectiveness. When managers were required to write clear logical narrative reports,
reflexivity was fostered. Clearly articulating the background, data analysis, rationale for and
impact of actions creates a space for managers to reflect on data and initiatives that are not
normally afforded to them in their everyday work. This assisted managers in picking up
issues, ‘it makes us go ‘oh my God why is that’. Okay let’s go back, . . . and fix things’ (quality
director, C3). Effective board questions also prompted valuable reflection and encouraged
managers to move away from operational perspectives, as explained:

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 . . . they ask different questions. They’re not in the business so much but they
have this governance responsibility . . . I can have seen the same report four times on its way up the
Creating time for discussion and challenge through agenda management was a key leadership process that fostered closer scrutiny of information.

Reflexivity was also fostered through leadership practices of reviewing effectiveness and data reporting at the governance level. Engagement with these reflective practices varied and occurred more often in high-engagement case studies. This echoes the greater engagement of these case studies in key communication and leadership processes as highlighted in Table III.

**Discussion**

This comparative case study of eight Australian public hospitals has brought to light key elements of communication, leadership and reflexivity that influence how well healthcare
The importance of open communication has previously been identified (Chambers, 2012; Millar et al., 2015). This study adds to existing literature by finding that open communication requires both managers who are transparent and board member who are receptive. Furthermore, managers framing discussions to promote board’s uneasiness with healthcare quality status was found to coexist with open communication in high-engagement case studies. Managers framing data to highlight risk supports a vigilant approach to governance and promotes open discussion and analysis of issues. This vigilance is similar to the ‘restless board’ proposed by Chambers et al. (2018) that constantly seeks to understand, benchmark and follow up issues. Communication framed to highlight risks and concerns provides a needed counterbalance to the tendency identified by Bismark et al. (2013) for boards to be overly optimistic about their healthcare quality performance, often due to a lack of reliable information on peer performance. The importance of framing to highlight risk is consistent with the finding of Jones et al., who found boards lower performing in quality improvement were more likely to put a ‘positive spin’ (Jones et al., 2017, p. 384) on poor performance.

Managers’ reports that use clear logical narrative assist board members to understand the background and progress with issues. Verbal and written reports that are concise and use non-technical language to present a ‘story’ foster board engagement through more questioning and discussion. Reports outlining the background, issues and actions enable board members to note items where no further action is needed or where issues are identified, discuss important aspects such as contributing factors and the effectiveness of action implementation. While governance literature is silent on a narrative approach, communication literature highlights its role in synthesising complex local knowledge embedded in organisations (Browning, 2006). Sole and Wilson (2002, p. 1) argue that complex knowledge is often inadequately conveyed in ‘harder forms of knowledge that can be classified, categorized, calculated and analysed’, such as quantitative data. Narrative communication can present local knowledge and convey an issue in a way that does not require specialist knowledge to understand what is meant (Browning, 2006; Hinyard and Kreuter, 2007).

Board’s engagement in effective questioning and challenge was an important aspect of communication in interrogating quality issues and has been noted previously (Freeman et al., 2016; Millar et al., 2015). This study found boards achieve this through simple questions, exploring contributing factors and action effectiveness, posed respectfully to managers as part of a quality improvement rather than a blame approach. Yet some board members expressed a lack of confidence in asking questions of their senior managers. Machell et al. (2010) highlight the literature that explains this reticence as a perception that questions may imply board members’ ignorance of issues. Managers actively encouraging board questions assist in overcoming board members’ reluctance to engage in a respectful challenge.

Literature rarely explores leadership beyond descriptions of the need for governing bodies to lead a healthcare quality focus (Jiang et al., 2012; Millar et al., 2013, 2015; Vaughn et al., 2006). A healthcare quality governance focus was found to encompass three possible areas: compliance, quality systems development and healthcare excellence. High-engagement case studies had a governance focus on pursuing healthcare quality excellence along with a quality improvement culture that fostered open discussion of quality issues. This finding is consistent with that of Jones et al. (2017), who reported that a healthcare excellence focus was a feature of boards’ higher performing in quality improvement.

Aligned leadership in the form of a shared vision for healthcare quality, led by the CEO and board chair and to a lesser extent the board quality committee chair, influences governance engagement. The CEO and board chair have an important role in promoting a focus on healthcare quality excellence among board members. Aligned leadership is consistent with a ‘post-heroic model of leadership’ (The Kings Fund, 2011) where
transformation is not derived from individual attributes of a single ‘hero’ but from adaptive, distributed and shared leadership. This form of leadership utilises collective influence, wisdom and skills to promote engagement in new practices that assist the organisation (James, 2011).

A board quality committee chair and staff convenor, normally a senior quality manager, are important in facilitating effective meeting processes. Effective processes of agenda setting and chairing discussions promote board quality committee participants to engage in healthcare quality governance activities. These leaders also facilitate processes of evaluating governance effectiveness, through reviewing data reporting, terms of reference and committee evaluations. This fosters governance participants to reflect on their governance purpose and effectiveness and to identify improvements. This finding is similar to that of Cornforth (2001), who in a survey of UK charity boards found, among other factors, that board and managers who periodically review how they work together were key in explaining variance in board effectiveness. The collaborative working relationship between board quality committee chair and staff convenor, seen in some case studies, reflects the interdependence of board members and senior managers noted in not-for-profits in the literature (Chambers and Cornforth, 2010; Cornforth, 2012; Harris, 1993).

Lastly, reflexivity emerged as a key factor influencing governance engagement in healthcare quality. Effective processes of communication and leadership create a mechanism and space for board members and senior managers to reflect on both the implications of data presented and their governance effectiveness. This reflexivity was observed to be less in low-engagement case studies and indicates people under pressure focusing more on immediate and action-oriented governance tasks rather than fostering opportunities for reflexivity, learning and development (Gray, 2007; Gurtner et al., 2007). This finding is similar to Kay and Goldspink (2015) identifying the value of critical board reflection in challenging assumptions and bias in a study of 100 chairs of Australian organisations.

The research presented has some limitations. Findings reflect the Australian context and need to be tested in other contexts to confirm their applicability. Furthermore, a range of other factors potentially mediating governance engagement not covered in this paper, such as conflict management and shared role understanding, require further exploration. The research used an indicator of healthcare governance engagement which was exploratory; however, this was derived from a systematic review of the entire dataset.

Conclusion
This paper has undertaken an in-depth exploration of how communication and leadership influence healthcare governance through a comparative case study of eight Australian public hospitals. Effective engagement in healthcare quality governance was characterised by key communication processes of open sharing and receipt of information, developing logical narratives and skilled respectful board questioning and challenge. Key leadership factors contributing to this engagement included an aligned leadership focus on healthcare excellence and effective meeting leadership processes. Board members and senior managers who engage effectively in these communication and leadership processes foster reflexivity. This is seen in managers evaluating healthcare quality information in greater depth and from different perspectives and in board members creating opportunities to review their governance efficacy.

This paper provides a more in-depth examination of communication and leadership in the exercise of healthcare quality governance than previously undertaken. Elaborating on key elements of these mediating factors provides practical guidance to boards and managers in understanding and enabling stronger communication, leadership and reflexivity at the corporate governance level.
References


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