Giving voice to quality and safety matters at board level: A qualitative study of the experiences of executive nurses working in England and Wales

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A R T I C L E   I N F O

A B S T R A C T

Background: Recent reports into egregious failing in the quality and safety of healthcare in the UK have focussed on the ability of executive boards to discharge their duties effectively. Inevitably the role of executive nurses, who's remit frequently includes responsibility for quality and safety, has become the object of increased scrutiny. However, limited evidence exists about the experiences of the UK's most senior nurses of working at board level.

Objective: We aimed to generate empirical evidence on the experiences of executive nurses working at board level in England and Wales. We posed two research questions: What are the experiences of nurse executives working at board level? What strategies and/ or processes do nurse executives deploy to ensure their views and concerns about quality and safety are taken into account at board level?

Design: Qualitative interviews using semi-structured interviews.

Setting: NHS England and Wales.

Participants: Purposive sample of 40 executive board nurses.

Methods: Semi-structured interviews followed by a process of thematic data analysis using NVivo10 and feedback on early findings from participants.

Results: Our findings are presented under three headings: the experiences of executive nurses working with supportive, engaged boards; their experiences of being involved with unsupportive, avoidant boards with a poor understanding of safety, quality and the executive nursing role and the strategies deployed by executive nurses to ensure that the nursing voice was heard at board. Two prominent and interrelated discursive strategies were used by executive nurses – briefing and building relationships and preparing and delivering a credible case. Considerable time and effort were invested in these strategies which were described as having significant impact on individual board members and collective board decision making. These strategies, when viewed through the lens of the concept of "groupthink", can be seen to protect executive nurses from accusations by board colleagues of disloyalty whislt also actively restricting the development of "groupthink" within the board.

Another finding of note was that executive boards may not be permanently fixed as either unsupportive or supportive as participants described how certain boards that were initially unsupportive adopted a more supportive attitude towards matters of safety and quality.

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Conclusions: These highly positioned nurses can provide invaluable advice and support to boards around matters of quality and safety. However, the work of nurse executives remains an under-research area and more work is needed to better understand the ebb and flow of power and influence at play within hospital boards.

What is already known about the topic?

- Very few studies exist that document the experiences of nurse executives working at board level in the UK or internationally.
- In the relative absence of research findings, evidence from inquiries and governmental reports into recent serious failures in patient safety in the UK provide important information. For example, these describe how the actions or inactions of dysfunctioning executive boards contributed to such failures.
- Nurse executives have been identified internationally as important members of executive boards, especially with regards to issues of protecting and promoting care quality and patient safety.

What this paper adds

- This study demonstrates that executive nurses make a valuable and significant contribution to board decision making, although not all board or board members are supportive of executive nurses and are not always focused on matters of quality and safety.
- The study describes several strategies deployed by nurse executives to ensure that board members take account of quality, safety and nursing matters when making decisions.
- Building relationships, credibility and an evidence base that supported the need to focus on quality and safety were important strategies used by the vast majority of executive nurses.

1. Introduction

Executive nurses are the most senior nurses within healthcare organisations, often having lead responsibility at board level for key elements of the care quality and patient safety agenda, such as nurse staffing levels, infection control and patient experience. As the most senior leaders of the largest portion of the health workforce, nurse executives have been identified internationally as having the potential to contribute unparalleled understanding of the quality of care that is being provided within the organization. (American Organization of Nurse Executives, 2007; Department of Health, 2013; The King's Fund, 2010) However, even though executive boards (see Box 1) of healthcare organizations have been identified as particularly influential in demonstrating commitment and organizational priority to quality and safety, (Dixon-Woods et al., 2013) there have been longstanding concerns in the UK about the lack of attention NHS boards afford to quality and safety, especially compared to the attention

given to finance. For example, a 2007 report in the UK described difficulties in reconciling cleanliness and the management of hospital acquired infections with the fulfillment of financial targets (Healthcare Commission, 2007).

More recent inquiries and reviews (Francis, 2013; Keogh, 2013) into egregious failings in the quality and safety of hospital care in England have also invited questions about the primacy of financial considerations over patient safety at board level, as well as the ability of nurse executives and boards more generally to deliver the necessary leadership around patient care. As a result, the Francis public inquiry(Francis, 2013) reinforced the call for more nursing influence at board level as nurses 'can provide invaluable advice and support to boards on a whole range of matters' and 'are well placed to resist corporate pressures to "toe the line" when patient safety is at stake' (p. 1526).

However, remarkably little research exists that explores the role and influence of senior nurse leaders in nurturing the culture change that government and healthcare organizations aspire to. For example, a recent large scale synthesis of evidence focusing on the performance of NHS boards (Chambers et al., 2013) made no mention of nurse involvement at board level and an international review of the literature (Parand et al., 2014) on the work of boards within the context of healthcare quality and safety discovered only one paper (Mastal et al., 2007). An in-depth mixed methods study (Mannion et al., 2016), published during the writing of this paper, provided some excellent insights into board governance in 4 NHS case study sites. However, providing a detailed understanding of executive nursing at board level was not the objective of Mannion et al. and only one study was discovered in our review of literature that provided such a level of insight. A narrative report (The King's Fund, 2010) of qualitative observational data provides detailed insights into the challenges confronted by nurse executives working on hospital boards in the UK, although few details about the study design are included. The report concurs with the findings of others(Francis, 2013; Mastal et al., 2007) when stating that 'clinical quality occupies a fragile position in many NHS boardrooms' (p. 26) but that nurse executives are well placed to change this and have some success in doing so.

We address this gap in the literature as our study aimed to generate empirical evidence on the experiences of executive nurses working at board level in England and Wales by examining their accounts and experiences of working at board-level. Our objective was to offer a better understanding of the role of executive nurses by developing seldom-heard and important insights into the attitudes, actions and experiences of some of the most senior

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Box 1. Typical membership and composition of NHS boards NHS boards in the UK are regionally divided. They have statutory responsibility for upholding the quality and safety of all clinical services operating within their region.

T Board members		Board composition and size
Executive Directors **Chief Executive** – leads the executive and the organisation. **Chair person** – leads the board and ensures the effectiveness of the board. **Chief Operating Officer** **Medical Director** **Executive Nurse** (sometimes referred to as Director of Nursing or Chief Nurse). **Director of Finance**	**Non Executive Directors (NEDs)** Independent board members who tend not to have a clinical or operational background in health-care quality. The overwhelming majority of NEDs (86%) in a recent study were drawn from commercial, financial or managerial background (non-clinical) (Mannion et al., 2016)	**Composition:** at least half the board, excluding the Chair, made up of independent NEDs. **Size:** NHS boards should not be so large as to be unwieldy, but must be large enough to provide the balance of skills and experience that is appropriate for the organization.

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nurses within the NHS. In doing so we draw on data from a large qualitative interview-based study of executive nurses in NHS organizations across England and Wales. The views provided by this group offer. We posed two research questions: What are the experiences of nurse executives working at board level? What strategies and/or processes do nurse executives deploy to ensure their views and concerns about quality and safety are taken into account at board level?

2. Methods

A qualitative descriptive study was undertaken with a total of 40 semi-structured interviews taking place between 24 February and 29 July 2014. This was a period during which patient safety recommendations and broader learning from a plethora of governmental reports, reviews and inquiries (Andrews and Butler, 2014; Clwyd and Hart, 2013; Francis, 2013; Keogh, 2013) was high on the agenda of executive nurses across England and Wales. Following approval from a university research ethics committee email invitations to participate in the study were sent via Chief Nursing Officers for England and Wales to the whole population of executive level nurses working within NHS England or Wales.

Participants were predominantly female ($n = 37$), with experience of working at this level ranging from two months to fifteen years (mean of 5.3 years) with one occupying an interim position; all were highly articulate when describing their roles and experiences as board level nurses. As executive nurses they were all appointed by and reported directly to their organisation's Chief Executive. Many spoke of Chief Executive's frequently being deposed with the new appointment resulting in a noticeable change to the organisational climate, for good or bad. We were satisfied with the number of participants recruited to the study consisting of approximately 10% of the total population of nurse executives in England and Wales, given that vacancy rates for such posts are currently around 20% (Health Service Journal, 2015) and participants typically reported a working week consisting of 12–15 h days supplemented by unpaid weekend working to catch-up on email backlog.

The sample consisted of participants from geographically diverse parts of England and Wales, although we are restricted by the risk of unintentionally identifying participants from divulging further detail here or in the findings about participants from specific geographical locations (for example there are only 7 board level nurse executives working in Wales). One of the authors (AL) conducted all interviews ranging from 15 to 90 min (mean = 48 min) in duration which were audiotaped and professionally transcribed.

The iterative and inductive process of analysis enabled the investigation of *a priori* research objectives while also allowing new themes to be identified in the data. The process of analysis was assisted by the use of NVivo10. Two researchers (AL and AJ) independently undertook initial coding of each transcript, before agreeing upon provisional relationships among the codes and aggregating these into preliminary overarching themes. A third researcher (DK) at this point ensured that the process of coding and identifying preliminary themes had accurately captured participants' meanings in the data set, whilst also addressing the aims of the research. This process underpinned by frequent, robust but collegial discussions between team members resulted in overlapping provisional themes being reduced into single overarching themes. In addition, we circulated a draft of the analysis to the respondents at the end of September 2014, to ensure that all were satisfied that the findings and quotations did not misrepresent their views. Four minor comments were received and addressed. Following this all the overarching themes were organized into the findings presented below.

Themes discussed in the findings and discussion sections are therefore rooted in the data collected and, due to the marked absence of research in this area, are largely free of prior theorizing on our part about the experiences of nurse directors. We were also guided by the assertion (Braun and Clarke, 2006) that 'the 'keyness' of a theme is not necessarily dependent on quantifiable measures' (p. 10) of prevalence within the data set. Although ideally there will be a number of instances of a theme within a data set, more instances do not necessarily mean the theme itself is more crucial. Instead, what counts as a theme also needs to capture 'something important' (p. 10) in relation to the overall research question (Braun and Clarke, 2006). With this in mind, we constructed themes that reflected the majority of our participants' experiences but which also conveyed a

sense of importance across the data set. In the findings sections we therefore refer frequently to the relative prevalence of a theme within the data set (using words such as "many participants", "the majority") but it is also imperative to bear in mind that the importance of a theme should not be diminished where prevalence is not mentioned

3. Findings

Our findings are presented under three headings. First we outline the experiences of executive nurses working with supportive or unsupportive boards. Next, we describe the strategies deployed by executive nurses to ensure that the nursing voice was heard at board meetings and describe two prominent and interrelated approaches used to this end – briefing and building relationships and preparing and delivering a credible case. The parenthesized numbers following data extracts are the unique identifiers we allocated to each participant.

3.1. Nurses experience of working on boards: the supportive, engaged board

Several participants described experiences of working with boards and board members that were attentive and supportive of nursing and disposed to open discussions.

> I'm quite lucky here, I've got a very good Chair, very good Exec and Non-Exec Directors, they really do pay attention to nursing and I think that's great, but I think that what I pick up is that that's not the case everywhere and we have to fight to get there (extract 1; 023)

> We all feel able to have a conversation and discussion in public at Board about what is happening, what are the issues and what does that mean for us. I work really well with my Chief Executive [...] and as a nurse I feel confident and therefore supported by that team (extract 2; 030)

Supportive boards were therefore characterised by executive nurses as being receptive and supportive of nursing issues, allied to openness when discussing nursing issues of concern. Others provided further details about what it meant to work with a supportive executive board. This included working with executive colleagues in an environment of honesty and opennesss where detailed, robust scrutiny of functions closely related to the role of nurse executives, such as care quality and patient safety, are permitted.

> I think the discussions that we have in our Board Seminars, as a bunch of Directors, is much more granular and gritty and honest than it ever has been because of Francis [The Francis Inquiry]. Because it's given us permission to lift the lid on any issue that can impact on patient care and safety and I think that's really powerful (extract 3; 023)

> Board has been very good at scrutinising quality, but clearly the focus has now increased significantly and we

have significant debate at the Board, both in the public and the private session, around quality and quality governance (extract 4; 086)

> I am the Lead Executive on infection control. Our Chief Executive is very clear about the fact that that safety is everybody's business, so that culture of everybody's business is something that I ... it's one of the reasons I want to work in this organisation because that singling out, which I've experienced in other organisations, for me, is much less in this organization (extract 5; 056)

> Chief Execs are very powerful positions, for obvious reasons, in organisations and (name of CEO) here, and one of the reasons I was keen to work here, it does have a really strong focus on patient experience, quality of care and safety in particular. I think that's important because it dictates how the rest of the organisation runs, so when the board is making decisions particularly around finance, we're doing that under the umbrella of how will it impact on patient safety and quality and that's the first question, how is this going to impact on patient safety and quality (extract 6; 036)

However, the experiences of other nurse executives were markedly different, as will be discussed in the following section.

3.2. Nurses experience of working on boards: the unsupportive, avoidant board

In stark contrast to those working with supportive boards, some participants described how executive colleagues had out-dated or non-existent understanding of nursing and a poor grasp of the role of the executive nurse

> Some of the non-execs couldn't understand why we have a Nurse Director, "what do you do", you know, type of approach [...] constantly feeling that you're being judged by peoples perception of what nursing is, rather than what it actually is. Everybody has a fixed view of what a nurse does and it's usually out of date. I find that you're constantly having to justify nursing and nurses (extract 7; 081)

These attitudes were not only confined to "non execs" (non-executive directors) however:

> the Chief Executive questioned the need for a Director of Nursing around the Board table when she took up the role and the fact that it was in legislation that we had to have an Executive Director of Nursing that's the only reason she had it (extract 8; 087)

This participant also described the board Chair as "bullying" and the powerful triad of chief executive, chief operating officer and chairman as inattentive and unsupportive of nursing, quality and safety matters

> What was said to me was I need to focus on finance, which I have to say, I was quite horrified at because that was said to me without even sitting talking to me about how we could sort the finances out and stay safe. One of

the issues that I was running into was the Chairman of my Trust I found him quite bullying and he seemed to be saying to me that he wasn't going to let me bring a report to board that he didn't agree with and yet he wouldn't sit down and talk through the report with me and the message I was giving to him very strongly was that I was required to bring a safety report and my role was to advise the board of what nurse staffing levels should be [...] it actually took the regulator to come in and give us a non-compliance before either the Chief Operating Officer or the Chief Executive took notice (extract 9; 087)

Others described similar avoidance of discussion of quality and safety issues when they had to convey discomfiting news to board colleagues.

I can remember losing the A&E [Accident & Emergency department] target, we got this thing 95% for the year and they'd just had a number of breaches in the emergency department and I thought "I think that's the target gone for the year". I can remember going back to talk to one of our Executive colleagues and said, "It's been very difficult down there as we realise we've just lost the target for the year". They just looked at me, turned around and walked away (extract 10; 040)

Unsupportive boards, in contrast to supportive boards, can therefore be exemplified as perpetuating a working environment where nurse executives found channels of communication were closed or severely impaired. This resulted in quality and safety concerns being underrepresented and unsupported at board level. Conflict between nurse executives and other members of the board was also prevalent, although this did not necessarily diminish nurse executives' voice at board meetings.

The reality is, as a Nurse Director you end up often having challenging conversations with your colleagues about well you want a cheaper workforce that's maybe not registered, but actually you want quality care and safe care, that's my responsibility and my advice is that that's not the right thing to do, and actually I will say at the Board that I don't think that's the right thing to do, so you sometimes find yourself in a conflict situation with your ops colleague (extract 11; 049)

The issue of care quality and safety would often occupy a fragile and embattled position within these boards. However, even where nursing was marginalised and conflict and bullying existed, participants courageously spoke out on behalf of quality and safe care. As we discuss next, study participants described how, through perseverance and being strategic, they managed to influence board decision making.

3.3. Strategies employed by executive nurses to influence board members and meetings

The following extracts demonstrate how nurse executives were successful in influencing boards that may initially have been reluctant to engage in discussion about care quality. Participants frequently described the process of influencing a board as a "fight" or a "battle".

There was virtually no quality reporting going to Board, and I introduced a quality report and there was discussion at the Board, well shall we see this quarterly? And I held out and said, 'No, we have to see this monthly'. In the end, we agreed that that was what would happen, but that was quite a battle (extract 12; 012)

Boards were told to consider patients stories at Board level, and my Chairman said 'I don't want that'. I then requested it when Francis inquiry came out so he e-mailed me then going 'I've re-thought about what you said [...] I think we should start doing it'. So you have to time your battles (extract 13; 084)

A number of interviewees described how they influenced the board towards greater engagement with care quality issues through deploying strategies related to briefing colleagues and preparing a robust case. These strategies will be discussed now in more depth.

3.3.1. "No surprises": Briefing work and building relationships

A common thread running through participants' responses was the amount of time and effort they invested proactively briefing other board members in the run-up to board meetings.

Rather than you know I'm going to bring a problem to the Board and not having told anybody like a lot of organisations you do a lot of your business just before you even get in to the boardroom (extract 14; 031)

An example of "doing business" before getting into the boardroom included briefing board members individually to prepare them for discomfiting news, thus ensuring there were "no surprises".

I know our problems in terms of nurse staffing and quality and by the November paper I'd already briefed the Board in private to get them to a position where they knew what I was trying to achieve and then when we came to the decision making actually, they were fully enough briefed on what was happening (extract 15; 030)

We had a Board Report that had a whole load of bad news in it and the Chairman had a little hissy fit when he read it but I sort of got him into the right place. So, by the time the Board came, he was saying "well I really welcome this, we're clearly not doing as well as we would like to be doing. What are we doing about it?" Some of that is you've got to sort of land those things so that they're not a sort of surprise (extract 16; 046)

Briefing therefore was important in preparing the ground for delivering potentially unwelcome information at board meetings. Closely aligned to this was the strategy of building relationships with fellow board members.

For me I think the biggest thing has been about relationships and managing relationships. Somebody said to me, just before I came in to post, 'just remember it's not about the knowledge you've got, it's about the way you handle people, and the relationships you build' and I absolutely think it is (extract 17; 085)

In terms of how I work with the Board, then for me it's about forming those positive relationships and making sure that they are briefed on issues [...] just tell them the situation, tell them what I'm doing about it, give them confidence that things are in hand, but that nothing is going to sort of pop out of the woodwork and surprise them (extract 18; 161)

In addition to preparing the ground for board meetings by building relationships with and priming board colleagues, executive nurses also described how they would embark on their own preparation prior to board meetings with the aim of delivering a credible case.

3.3.2. "Mental aerobics": preparing and delivering a credible case

Prior to board meetings participants discussed how they undertook rigorous preparation in terms of understanding reports tabled by other board members as well as rigorous presentation of their own board reports.

I try and make sure I've done the mental aerobics around thinking, well what's the nursing contribution to this? (extract 19; 081)

Making sure the Board is aware, making sure that they have good information, and that the papers are set out very clearly in order that the Board can understand [...] I am very detailed in terms of my preparation and in terms of having read everybody's papers and tried to do the read across of what everything means to each other, so what are the similarities? What are the threads I need to pull out when I'm presenting either the quality or the nursing papers? Which are linked to the performance report or linked to the HR report? So I think that's an important thing for me to do (extract 20; 030)

The need for detailed and careful preparation of board reports was allied to the importance of being regarded as credible by board colleagues. This involved a process of reputation building.

It's not sort of, you know, what you do, as a one off, in a one off way, in a Board discussion. I think that you have to be in a position where Board Members believe you to be credible, competent, that you've got a track record of producing things that they want to see (extract 21; 046)

Being seen by colleagues as credible was also linked to executive nurses being strategic about how and when they interjected at board meetings. This signalled that credibility, at least in the minds of these executive nurses, was closely related to demonstrating discursive competence to board colleagues

I don't tend to interject or talk until I've got something significant or a proper contribution, and therefore,

people know I've got evidence, then it's real, I'm not one for over-egging anything (extract 22; 054)

The practice of speaking in a measured way during board meetings was also echoed by other participants.

I think my other strategies are [...] to not be over-vocal but make sure if I am concerned about something, that I raise it and I say it in such a way that Board Members are going to take notice (extract 23; 038)

Akin to this was the ability to translate nursing issues to fit with the perspectives and priorities of others on the board:

So if our business is about quality and safety at Board it's about trying to build a narrative, trying to paint pictures around the implications of some of the things that are under discussion and what the likely impact of those would be. I suppose in some ways it's talking the language that other members of the Board talk as well, so talking about risk, talking about mitigation, trying to identify financial costs, reputational cost [...] having information to support arguments, so rather than going in and going, I think the sky is going to fall on our heads and we're doomed, you say I think we've got some issues and this is why I'm telling you, because this is the information that I have. This is the data I can bring to you to support my rationale and my argument (extract 25; 040)

4. Discussion

Our analysis identified the variable experiences of working at board levels of nurse executives, with some participants describing open, constructive and mutually respectful working relationships where discussion of nursing, quality and safety between executive members was robust and detailed. On the other hand, others described repeated experiences where executive teams were ill-informed and consistently hostile towards the nurse executive role. As a result, discussions about clinical issues that are central to the functions of executive nurses, such as quality and safety, were marginalized or disregarded by individual board members or by boards collectively. We have therefore categorized boards (see Table 1) as "supportive/engaged ("type a" board) and the alternative "unsupportive/avoidant" ("type b" board). Whilst it is possible for boards and board members to periodically demonstrate unsupportive behaviours towards nurses during a meeting or other such one-off encounters (perhaps akin to someone having a "bad day"), a clearly defining feature of the data about type b boards was the ongoing and consistent lack of support and avoidance of nursing concerns.

However, close scrutiny of the data reveals that attitudes of boards and board members to executive nurses and matters of quality and safety are not always static, but can be in a state of flux ("type c"). For instance, numerous examples were provided where nurse executives influenced a "type b" board to adopt "type a" features. Although such a "sea-change" in a board's attitudes would become apparent at a specific meeting or point in time, executive nurses described how their influencing strategies were often deployed

Table 1
Emerging typology of hospital boards from executive nurses viewpoints and their defining features.

Type a: Supportive-engaged boards	Type b: Unsupportive-avoidant boards	Type c: Boards in flux
Defining features: Clear understanding of executive nurses role. Issues of care quality and safety discussed in a robust manner.	Defining features: Consistently poor understanding of executive nurses role. Issues of care quality and safety repeatedly marginalized or completely avoided.	Defining features: boards stance towards quality and safety is changing, moving from type b to type a defining features.
See extracts: 1, 2, 3, 4, 5, 6, 13, 14	See extracts: 8, 9, 10, 11, 12, 13, 14	See extracts: 13, 14, 16

longitudinally over significant periods of time and resulting in considerable energy being expended by those nurses.

It is therefore important to note that executive boards may not be permanently fixed in their unsupportive attitudes to nursing and related areas such as safety and quality. We also acknowledge that the reverse may also be possible, where type a boards may also be in a state of flux towards type b, although we have no evidence of this in our data. Overall, however, having to work with unsupportive boards was more commonly described by our participants. Other UK research have recently discussed unsupportive board behaviours within the context of numerous long term vacancies for, and lack of long term occupants of executive nurse posts (Osbourne, 2014; The King's Fund, 2014). It is also interesting to note that two nurse executives (extracts 5 and 6) explicitly describe how a board and chief executive's reputation for being supportive and focused on the quality of care had positively influenced their decision to work in the organization. We therefore recommend that future studies explore in more depth the ebb and flow of power and influence at play within hospital boards, focusing for example on the effect that individual members or shifting coalitions of members may have on the collective stance of the board towards matters of safety and quality and in terms of the board's aggregate effect on organizational outcomes as a whole.

Regardless of the type of board they worked with executive nurses consistently deployed a range of skills that worked to engage board members with their concerns about quality and safety. Two sets of interrelated discursive activities were described by the vast majority of executive nurses interviewed, namely "Briefing and building relationships" and "Preparing and delivering a credible case", which were central to how they maintained or enhanced their influence at board level (see Table 2).

Participants described having to spend considerable time and effort crafting and sharing arguments that mediated and reconciled the sometimes conflicting worlds of clinical practice and executive management. This mediating role required skills of "discursive competence" that included being able to "sell" important issues of quality and safety by knowing when and how to say something to members of the board. Our analysis enabled us to also understand some of the detail surrounding these conversations, demonstrating, for example, how nurses sought credibility with colleagues by producing timely, clear and detailed narratives about safety and quality, whilst not "over-egging" or being "over-vocal" about every issue of concern. This final point evokes recent recommendations (The King's Fund, 2010) that suggest nurse executives should be wary of being stereotyped (and therefore easily ignored) as the 'bleeding heart' (p. 21) of the organization. Instead, nurse executives in our study adopted the role of an "attuned tactician" who carefully chooses and plan their battles.

Nurse executives' tendency to brief and build relationships outside of the boardroom may also, however, suggest a lack of confidence in their own ability to raise issues of concern within board meetings. This, in turn, may be associated to some of the nurses lacking the formal authority of those more traditional corporate roles at board level. For example, nurse executives working with executive colleagues who openly question the need for nurse representation in the boardroom would undoubtedly lack forms of persuasion and legitimacy that accrue to those with traditional, hierarchical based means of influence such as Medical Directors or Chief Operating Officers.

The consistent effort expended in briefing and building relationships with individual board members outside of the boardroom may also be an useful tactic in countering what others have identified as the potentially insidious influence of "groupthink" on board decision making (Maharaj, 2008; Mannion and Thompson, 2014; Mannion et al., 2016). The concept of groupthink is defined as 'a deterioration of mental efficiency, reality testing and moral judgement that results from in-group pressures' (21: p. 9). Such in-group pressure can lead to homogeneity of thinking, where group members collectively discount warnings or other information that may threaten the group's uniformity (Maharaj, 2008). According to Janis, who first coined the term groupthink, group harmony and unity may be favoured to such an extent that 'loyalty requires each member to avoid raising controversial issues' (21: p. 349). Furthermore, those who disrupt group loyalty, for example in the interests of patient safety, may be bullied for their efforts (Maharaj, 2008).

Viewing the nurses actions through the lens of groupthink allows us to see how shaping board colleagues' opinion through individualised briefing and relationship

Table 2
Strategies used by executive nurses to influence the board.

Briefing and building relationships:
- Briefing for "no surprises"
- Building credibility

Preparing and delivering a credible case:
- Discursive competence
- Information preparation and "Mental aerobics"
- Delivering a credible case

building outside of the boardroom, may serve to protect the executive nurse from accusations of disloyalty or disrupting the uniformity of the collective board. In addition, the executive nurses acts of sharing information and building effective interconnections among all board members has been identified within the business literature as an effective defence again board members becoming adversely affected by groupthink in the first place (Maharaj, 2008). We agree with others (Mannion et al., 2016) that it would be useful to undertake more research into group decision making at board level, especially the potential for decision making bias to disrupt patient safety processes and outcomes.

5. Conclusion

Nurse executives frequently reported experiences of speaking up in the boardroom or to individual board members in an attempt to protect and promote the interests of nursing and the safety and quality of patient care, sometimes doing so despite displays of outright hostility and indifference by their executive colleagues. The determination of some of the executive nurses in changing a board's attitude towards quality and safety supports the point made in the introduction that these highly positioned nurses can provide invaluable advice and support to boards as they can resist corporate pressures to 'toe the line'.

However, the work of nurse executives remains an under-researched area. Further longitudinal exploration of the contribution of nurse executives to healthcare quality and safety, both from an executive team and clinical perspective represents a promising area for future research and development. Equally, it is important to acknowledge the limitations of this research, which relied on interviews at a single point in time. Observational data allied to documentary analysis would provide richer data and help to further refine our understanding of the work undertaken by nurses working in the higher echelons of healthcare.

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