1 Introduction

Governance and leadership play a key role in delivering high-quality, safe care. In this Element, we set out what is meant by *governance* and *leadership*, discussing the way thinking has developed over time. We describe the role of governance and leadership in quality and safety at different levels, from the team or individual level to national policy. We discuss board governance, performance management, the influence of leadership on improvement efforts, and team-based leadership. Finally, we draw out lessons for practice, policy, and research, noting particular strengths and weaknesses in the evidence and what this means for governing and leading for quality and safety in healthcare settings in the future.

2 Why Are Governance and Leadership Important to Healthcare Quality and Safety?

We begin by outlining the role of governance and leadership in quality and safety (Section 2.1) and show that they can operate at multiple levels (Section 2.2), before we then go on to examine how governance and leadership might be defined and explain how thinking has evolved over time (Section 3).

2.1 The Role of Governance and Leadership in Quality and Safety

The central role played by governance and leadership in the actions (and inactions) relating to quality of care and patient safety has been repeatedly identified by inquiries and investigations into major organisational failures.[1] For instance, the 2002 inquiry into paediatric heart surgery at Bristol Royal Infirmary in the 1980s and 1990s[2] (also discussed in the Elements on statistical process control[3] and making culture change happen[4]) identified that there had been insufficient prioritisation and monitoring of quality, as well as a culture that failed to acknowledge problems. The recommendations of the Bristol inquiry were a key driver for the subsequent development of clinical governance ('inter-related activities aimed at improving the quality and safety of health care'[5]), which remains an important component of healthcare quality in the UK National Health Service (NHS).[1,2,5–7]

Despite efforts to improve care after the Bristol inquiry, problems have recurred. Investigations into higher-than-expected death rates at Mid Staffordshire NHS Foundation Trust in the late 2000s identified multiple failures of governance and leadership throughout the organisation and the wider system. These included the failure to monitor and enforce standards, insufficient transparency and involvement of patients and the public, and gaps in regional and national leadership.[1,8,9] More recently (2015), an investigation into serious incidents in Morecambe Bay maternity services found that poor processes for

learning from adverse events, deficient clinical skills, and inadequate teamworking contributed to the organisation's failure to maintain standards, which in turn resulted in serious incidents, including the deaths of mothers and babies.[10]

These inquiries and other investigations have consistently identified that organisational and system failures result from a combination of many interrelated factors. They also show that governance and leadership – through their influence on priorities, oversight, and management and culture – are often part of both problem and solution.

2.2 Governance and Leadership at Macro, Meso, and Micro Levels

Governance and leadership of healthcare operate at several levels. Here, we distinguish between macro (national), meso (organisational), and micro (team or individual) levels (see Figure 1).[11,12]

- In some systems, macro-level governance sets overarching direction and priorities for quality and safety (e.g. national recommendations), and may feature a variety of bodies serving different functions, including regulatory roles.[9,10,13]

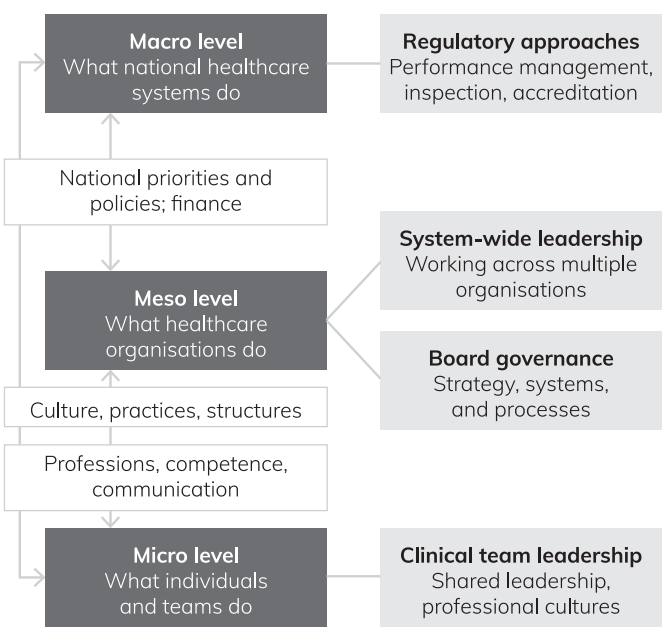

Figure 1 Governance at macro, meso, and micro levels with reference to examples discussed in this Element

The figure draws on work by Fulop and Ramsay.[11]

- At the meso level, organisations develop and implement strategies aimed at delivering high-quality, safe care to the populations they serve.
- Finally, at the micro level, frontline staff deliver this care.

These layers are heavily intertwined, with many points where different levels of governance and leadership interact. For example, at the macro (national/regional) level, a range of bodies may set policies, issue guidance, allocate resources, and operate incentives. Regulators may set standards and put mechanisms in place to oversee them and take action where needed.[14] At the meso (organisational) level, board governance may seek both to influence upwards into national priorities and to influence within their own organisations, and to bridge national drivers and frontline activity.[12,15] Understanding the interactions between these macro, meso, and micro levels is an important part of understanding how the quality and safety of care can be maintained and improved. In Figure 1, we describe these levels, some key processes, and where the examples selected for discussion in this Element sit in relation to these levels.

3 A Brief History

This section will discuss how thinking about governance and leadership has changed over time. It begins by setting out how the concepts have been defined, and the relationship between the two concepts. It then addresses how thinking about governance and leadership has evolved over the twentieth century to today.

3.1 What Is Meant by Governance and Leadership?

Governance and leadership are overlapping concepts with a complex relationship. Governance has been described as an 'elusive concept to define'.[16] The term derives from Latin words for 'to steer' or 'give direction'.[17] Its current meaning might be explained as follows:

- the means for achieving direction, control, and coordination of wholly or partially autonomous individuals or organisational units on behalf of interests to which they jointly contribute[18]
- ways in which organisations and the people working in them relate to each other[19]
- a set of processes (customs, policies, or laws) that are formally or informally applied to distribute responsibility or accountability among actors of a given [health] system.[16]

Therefore, governance may be seen in terms of the structures and processes that enable oversight, monitoring, and accountability within that system; but it is also important to note that any formal processes and structures may be shaped

by (and should accommodate) the informal interactions between people operating within that system.

Leadership also tends to attract multiple definitions, but it can perhaps be summarised in terms of processes by which individuals or groups are enabled, encouraged, or inspired to achieve agreed goals within a given context. A common theme across various definitions is 'mobilising individuals, organisations and networks to formulate and/or enact purposes, values and actions which aim or claim to create valued outcomes for the public sphere'.[20]

There are important overlaps between the concepts of governance and leadership, for example, in terms of the aim to influence how people operate within a system or service. However, while the concepts overlap, they play different (yet interlinked) roles. That is, governance is a system that enables oversight, monitoring, and accountability of the processes and people operating within it; leadership may be seen as a key component of a governance system, acting both to influence and facilitate that system (e.g. shaping strategic vision and objectives, and enabling engagement with system processes).

3.2 How Has Thinking about Governance Changed?

Approaches to and thinking about governance in healthcare changed during the twentieth century and into the twenty-first century, reflecting broader social and political changes.[19] Traditionally, some healthcare professionals (e.g. doctors) operated forms of professional self-governance, in that they worked independently to deliver care while also gaining direction through their peer networks – for example, via the General Medical Council, established to regulate doctors in 1858,[21] and the General Nursing Council, established in 1919.[22]

Bureaucratic hierarchies emerged in the early to mid-twentieth century, characterised by a centralised authority implementing structures and rules in order to exert influence across the entire system. A key example was the hierarchical command and control approach of the NHS from its post-war inception. This system was led by a minister of government and the state department (the current equivalents being the Secretary of State for Health and Social Care and the Department of Health and Social Care, respectively) exerting influence through layers of authority all the way through to frontline delivery of care. The approach reflected the *big government* thinking that shaped the welfare state in the UK in the mid-twentieth century; it was embodied in the suggestion of Nye Bevan, the minister who oversaw the creation of the NHS, that 'when a bedpan is dropped on a hospital floor its noise should resound in the Palace of Westminster'.[23]

The command and control approach to running the NHS broadly continued until the 1980s when many nations, including the UK, parts of mainland

Europe, and New Zealand, began to adopt principles of market forces. This so-called *new public management* approach has been associated with the emergence of the 'new right' (e.g. the conservative movements led by Margaret Thatcher in the UK and Ronald Reagan in the USA in the 1980s). Drawing on private sector thinking to reshape approaches to running public services, including healthcare,[24] common features included:

- reduced centralised, hierarchical control accompanied by more corporate approaches to governance and management were introduced (e.g. introducing board governance)
- a purchaser–provider split and competitive tendering to deliver services
- a move from professional self-regulation to external audit and regulatory governance.[24]

Policy-makers anticipated that these changes would lead to greater entrepreneurialism and better quality care.[23] In practice, however, some research suggests that the shift to new public management may have been associated with reduced professional engagement, local democratic influence, and creative central policy-making, as well as depleting local capacity to balance long-term and short-term priorities.[24]

Since the early 2000s, the concept of *network governance* has grown in prominence as a possible way of enhancing collaboration between organisations while also engaging more effectively with a wider range of stakeholders, including the public, the voluntary sector, and frontline staff.[19,25,26] It may take a variety of forms,[25] with an important example the introduction of managed clinical networks for cancer services, which sought to assist in delivering the NHS national cancer plan.[27–29]

In practice, many health systems do not reflect different forms of governance in a pure sense, but rather in combination. For example, the current English NHS is characterised by overlapping features of markets (e.g. the purchaser–provider split) and network governance.[25] At the same time, bureaucratic governance (e.g. the enduring hierarchical influence of the Department of Health and Social Care and NHS England and Improvement[19,30]) and external regulation (e.g. operated by bodies such as the Care Quality Commission [CQC] and professional regulators[30–32]) are both highly consequential for the ways in which organisations providing care design and operate their own systems for governance and their leadership behaviours.

3.3 How Has Thinking about Leadership Changed?

Traditionally, thinking around leadership focused on the idea of *born leaders* and explored how individuals drew on their inherent qualities to lead others – the

heroic leadership model.[33,34] Over the course of the last century, the focus shifted to characteristics commonly possessed by leaders (known as trait theory), and how leaders acted (behavioural theory). Contingency theory, which emerged in the 1950s, moved the focus to the relationship between leaders, their actions, and the organisational and wider contexts in which they operate.[35] Since the 2000s, research has increasingly addressed how leadership accommodates complexity within teams, organisations, and the wider system.[36,37] That is, individuals, groups, or organisations within a given setting may hold different and sometimes competing priorities, even when they are working towards a shared goal of improving quality and safety of care.

Researchers have also drawn a distinction between leadership strategies: 'transactional' strategies involve use of rewards and punishment to motivate, whereas 'transformational' strategies involve use of charisma, challenge, and individual focus to win others' trust and emotional buy-in to drive improvements.[38] Further, there has been a shift in perception from *leader as commander* to *leader as engager*, where leaders stimulate more collective approaches to leading on improvement.[39]

Understanding of *who* it is that leads has also changed over time. At micro-service level, different staff groups have traditionally held different leadership responsibilities. For example, doctors tended to hold greater autonomy to influence practice and guide improvement than nurses.[40] But with the development of new public management in the 1980s, power shifted from professionals to managers as boards came to set priorities and facilitate improvement.[24] This seminal change was initially prompted by the Griffiths review into NHS management (1983), which reported that the NHS was unclear on objectives, performance, and quality, with little sense of who was in charge.[41–43] However, there is now growing recognition of the value of having a strong clinical voice in senior management.[44,45] This has led to development of 'hybrid' leaders who combine clinical and managerial roles and so may influence improvement both formally and informally.[46,47]

There have also been attempts to move beyond models of heroic individuals to consider models of shared leadership.[40,48] 'Distributed', 'shared', or 'collective' leadership proposes that leadership does not sit with one individual; rather, it encompasses anyone in an organisation or system who has a role in leading or managing activity – this includes middle management and frontline staff.[48–51] There is some evidence that high-performing healthcare organisations and clinical teams are more likely to feature aspects of shared leadership, while also retaining clear strategic direction from the top.[52,53] However, as we discuss later (Section 5.1), the effectiveness of distributed leadership may be influenced by context; for example, there are likely to be particular challenges when attempting to implement distributed leadership across complex systems that cover multiple organisations and sectors.[48,54]

4 Approaches in Action

In this section, we present evidence on how governance and leadership influence quality and safety. While we discuss evidence on governance and leadership separately, the two issues are closely intertwined. Section 4.1 describes how aspects of governance influence quality and safety. Sections 4.2 and 4.3 explore how board governance helps improve quality and safety, and the relationship between performance measurement, performance management, and regulation. Section 4.4 discusses leadership's contributions to quality and safety at macro, meso, and micro levels. Sections 4.5 and 4.6 illustrate these relationships in terms of leading major system change and how team leadership influences quality and safety.

4.1 How Does Governance Influence Quality and Safety?

The challenge of steering organisations and individuals to improve quality and safety can be framed in a number of ways.[53] For example, agency theory suggests the task is to develop systems and processes that manage individuals' self-interest,[53–56] whereas stewardship theory assumes individuals are all working towards the same goal and that the task of governance is more facilitative.[53,56,57] But whatever the conceptual model, governance typically involves setting strategy, ensuring accountability, and fostering an appropriate culture,[56,58] as outlined below.

4.1.1 Setting Strategy

Setting a long-term strategy refers to an overarching plan that describes how the organisation's values and priorities are to be achieved. It is important that strategy is linked to clear and measurable quality goals. National policies or standards at system level typically frame the context in which healthcare organisations operate and the priorities they seek to achieve.[11,59] Closer to the front line, organisational strategies for quality set the tone for staff and teams, while also framing the objectives against which performance is measured (e.g. see Section 4.2 on contributions of board governance to quality and safety).[12,50,54,58–60]

4.1.2 Ensuring Accountability

Effective systems of accountability – monitoring and measuring performance, perhaps linked to meaningful incentives – are critical elements of governance of a quality strategy. At the macro level, such systems are visible in national regulation and inspection processes.[11,20] Within organisations, boards may develop and implement local audit and clinical governance processes.[43,50,59,61–64]

4.1.3 Fostering Culture

Shaping *culture* (the 'shared aspects of organisational life'[65]) has a vital part to play in ensuring that long-term strategies and systems of accountability can work most effectively. Cultures that explicitly prioritise characteristic features of high-quality care delivery (for example, commitment to improvement, patient experience, engagement, and teamwork) are thought to support better care.[50,59,66] However, a review of the evidence cautions that conventional assessments of organisational culture are often too simplistic, since organisations are often home to a multitude of cultures at the micro level. Further, the interrelationships between organisational culture and improving quality and safety are likely to be complex; for example, culture may influence different improvement activities differently, and the culture itself might be shaped by how an organisation delivers on quality.[65] Further discussion of some of the issues relating to culture can be found in the Element on making culture change happen.[4]

4.2 How Board-Level Governance Can Contribute to Improving Quality and Safety

We have already identified three important governance roles for boards: setting strategy, ensuring accountability, and fostering culture. In this section, we discuss how boards enact their governance roles to support delivery of high-quality, safe care, presenting evidence on how boards interact with both the organisations they govern and their wider context.[45,55,60,64,69,70]

'Board governance' refers to the systems and processes used by senior leadership in healthcare organisations to support delivery of key organisational priorities, including high-quality, safe care.[45,55,60] Boards are accountable for the quality and safety of care in the organisations they lead.[45,55,60,71] But these are not boards' only priorities; others include, for example, resource management, finances, innovation, population health, workforce, and equality and diversity. To govern effectively, boards must achieve an appropriate balance between all these priorities.[60,72]

What boards do and how they do it is important to the quality and safety of care that their organisations provide.[1,45,55,73] Evidence from the USA and the UK suggests that boards tend to perform better on quality and safety if they make quality a strategic priority, dedicate time to discussing quality in board meetings, and establish dedicated quality committees.[52,60,70,74,75] In the following sections, we discuss some of the ways in which boards can strengthen their focus on quality.

4.2.1 Using Strategy to Drive Quality

A key role of boards is to set the strategy for the organisation they lead. Quality should be at the heart of this strategy.[60,72] Research on boards in Australia has identified the importance of translating broad strategic statements into specific, meaningful quality objectives, since, in the absence of such statements, board members and staff struggled to discuss progress on improvement.[76]

An analysis of the approaches used by English boards to enable quality improvement (QI) used an evidence-based measure that reflected the degree to which boards prioritise, understand, engage with, and support QI – referred to as QI 'maturity'. This study indicated the importance of both the amount of time dedicated to quality *and* its focus. Boards of organisations with high QI maturity spent the bulk of their time discussing quality and prioritising issues that had been escalated by the quality committee, trusting the wider governance structure to identify the issues that required attention.[45]

4.2.2 Engaging Stakeholders at All Levels to Build Cultures that Prioritise Quality

Boards that are effective at leading improvement achieve it by engaging stakeholders at macro, meso, and micro levels (reflecting their accountability to different levels of the system) and translating this engagement into strategic priorities.[77–79] Such boards seek to manage their wider environment – including regulators, payer organisations (commonly described as commissioners in the English NHS), and fellow provider organisations – in order to support region-wide responses to quality challenges. Equally, they may engage with local stakeholders to build cultures that are supportive of improvement, patient engagement, and teamwork.[52,60,80–82] For example, boards of the organisations judged to have high QI maturity were found to engage actively with stakeholders, including clinicians and patient groups, so that different stakeholders could help shape organisational priorities for quality.[45]

4.2.3 Using Data to Ensure Accountability and Drive Improvement

Boards that are successful in focusing on quality make use of data to drive improvement, rather than just for external assurance.[45,61] They do this by clearly defining what is meant by quality and endorsing its associated measures. They create and regularly review a quality monitoring framework, analyse performance against benchmarks over time to identify areas of improvement, and assess progress on areas of concern.[1,45] Drawing on a combination of hard quantitative data on performance and soft data (e.g. discussions with clinicians or patients, or walk-arounds by senior management) has been found to help

boards understand the realities of quality and safety on the ground and to help make a compelling case for improvement.[45,64,73,83,84]

4.2.4 Communication and Information to Support Understanding and Prioritisation of Quality

Effective communication about quality at board level – for example, presenting clear narratives on quality while being open to questioning and challenge – can help offer board members the space to reflect on the reasons for any quality and safety issues, and potential solutions.[85] Also important is the capacity to use, interpret, and act on available data. Boards of Australian organisations with low engagement with quality described themselves as 'drowning in data',[45] while English boards with low QI maturity received data that made it 'hard to see the wood from the trees'.[85] Boards with high QI maturity, on the other hand, outlined the use of benchmarks linked directly with improvement priorities[45] and managers created a logical narrative through the data, thereby facilitating rapid understanding and better engagement from board members.[85] Boards with high QI maturity highlighted the advantages of effective challenge (e.g. questioning assumptions behind analyses and actions) in creating a wider understanding of quality issues across the board.[45,85] They also set in place communication systems that aimed to support shared understanding of quality issues across departments and professions at every level.[45,78,86]

4.2.5 What Helps Boards Govern for Quality?

Boards can be helped to carry out their governance roles by ensuring they have the appropriate membership and that board members continue to develop their capabilities in relation to quality. Board membership needs to be sufficiently large and sufficiently diverse to provide the necessary expertise to govern complex healthcare organisations.[60,64] For instance, research on healthcare organisations in the UK, USA, and elsewhere suggests that a higher proportion of doctors on boards has been associated with better performance on quality ratings and patient outcomes.[87–89] This may be because clinicians offer greater understanding of quality and safety, and communicate more effectively with clinical staff.[69,87,88] However, how these clinicians behave also matters: boards with high QI maturity included clinicians who were assertive and vocal on matters of quality; less mature organisations had fewer such members.[45] The balance of executive management and non-executive (lay) members is also important.[72] Non-executives, ideally with expertise in quality and safety, provide a valuable perspective in scrutinising performance – challenging senior management on quality and safety and how they are balanced against other organisational priorities.[55]