Cambridge Elements

Improving Quality and Safety in Healthcare

Governance and Leadership

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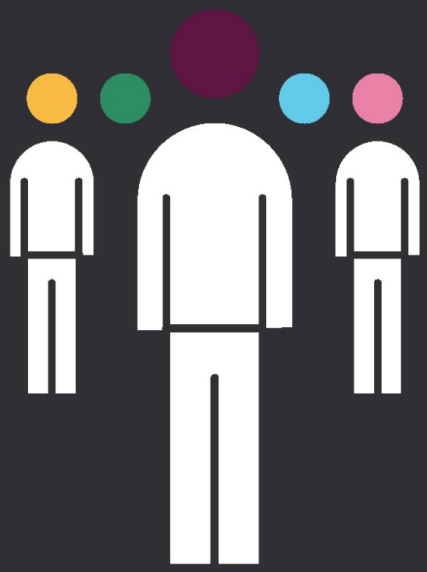

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1 Introduction

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

- **Team building and maintenance:** a team approach was taken in both day-to-day activities (e.g. by managing group dynamics to ensure all voices were heard, or creating clear and consistent boundaries for team member roles) and formal and informal team exercises (e.g. team-based development activities or social events).
- **Emotional intelligence:** staff referred to the importance of empathy, communication, and openness to help staff feel valued and understood and to promote healthy communication across the team.

constructive feedback, leaders are able to make staff feel valued, confident, and more part of the team (see Box 4).[144]

Supporting the team in discussing, learning, and collaborating around quality appears to result in better problem-solving and a stronger sense of team membership and common goals.[136,144] This is supported further by creating a clear sense of team identity and purpose.[136,144] For example, research on mental health teams has indicated the importance of having team leaders who can chair team meetings effectively. When team leaders were able to create a space for the team to agree key care decisions, share ideas, and work through disagreements constructively, this set the tone for the team.[141]

The task of team leadership may become more complex when teams cover more than one profession or sector. Staff in integrated teams reflected that health and social care have different leadership cultures: social care is less hierarchical than healthcare and has more formalised mechanisms of support for staff.[144]

4.6.2 Task-Focused Leadership

Task-focused leadership relates to the processes by which team goals are achieved. Having a shared sense of objectives, responsibilities, and delivery helps to ensure that all team members are working to achieve the same quality goals; and, as goals become clearer, so does team effectiveness.[116,136,137,144] Next, building expertise (e.g. by addressing gaps in knowledge or skills and enabling access to training) increases the team's capabilities to deliver high-quality care.[116,136,144] Then, leading beyond the team, in order to promote it with stakeholders within and beyond the organisation, can improve access to shared resources (e.g. diagnostics) and help to build wider networks across local systems.[116,136,144,146]

Underlying these processes are team leaders' personal qualities: in addition to expertise and focus on quality and innovation,[136] they bring enthusiasm, empathy, emotional intelligence, and communication skills.[136,144] Staff in integrated community teams highlighted the importance of a team leader who could

'walk the talk' and act as a role model for other members of the team, and they emphasised the importance of leaders who maintained a positive, constructive approach during difficult times.[144]

5 Critiques of Governance and Leadership

5.1 Navigating the Complex Challenges of Governance and Leadership

There is probably no single best way to govern or lead for improving quality and safety. The examples explored in this Element show that the effects of governance and leadership are strongly influenced by context at the macro, meso, and micro levels. Contingency theory suggests that different styles of governance may work better depending on circumstances. For example, inward-focused organisations (those that focus mainly on internal processes) may achieve greater staff commitment, while outward-looking organisations (those that prioritise the wider context, including neighbouring organisations, regulators, and policy-makers) might engage more effectively with external regimes.[67] Important influences include policy priorities and organisational challenges – factors that should not be seen in isolation but understood, rather, as highly interrelated.[20,40,116,120,147–149]

Earlier, we highlighted a number of unintended consequences of some approaches to governance, including the risks of reduced capacity to balance long-term and short-term priorities, reduced creativity in central policy-making (Section 3.2), and downsides associated with target-driven regimes (Section 4.3). We also showed that adapting approaches to healthcare governance from those used elsewhere – for example, importing thinking, structures, and processes from the business sector (Section 3.2) to inform new public management – is not straightforward. The question of stakeholders illustrates some of these complexities: while governance in the business sector relates to shareholders, the main stakeholder in a public health system could be said to be society in all its guises.[12,24,60,62] As a result, there are active debates about how to ensure democratic, public accountability[12,24] and how best to involve the public in making decisions about major changes to the organisation of care.[131,132] Closer to the micro level, the example of root cause analysis, a technique originally used to investigate incidents in industrial settings, further illustrates some of the challenges of transferring learning into healthcare. In industrial settings, root cause analysis operates as a learning technique and prioritises the avoidance of blame. In healthcare settings, however, root cause analysis may take on additional functions of establishing responsibility for an incident and extending organisational surveillance and control; this in turn reduces the envisaged learning benefits.[150]

valuable.[162–164] Longitudinal, theory-driven research of this kind can help open up this black box to explain how governance and leadership influence quality and safety. We have highlighted several examples of such research in this Element, but more are needed; given the powerful influence of context there is a clear need for further research to be conducted in a range of settings. As research funders continue to prioritise such work, we anticipate that understanding of these complex relationships will continue to grow over the coming years.

6 Conclusions

This Element has analysed how governance and leadership shape and influence organisation and delivery of healthcare quality and safety at macro, meso, and micro levels of the system. Governance and leadership may contribute both to significant improvements and major failures in delivering high-quality, safe care, so it is important to get them right. We have described conditions that might help to ensure that performance measures, targets, and regulatory activities support rather than hinder organisations in improving quality (e.g. aligned targets, sufficient organisational capacity). We have outlined behaviours that may help boards focus more effectively on improving quality (e.g. prioritisation of quality, focused discussions informed by a range of hard and soft data, engaging stakeholders both within and beyond the organisation). We have also set out how different leadership approaches contribute to delivering major system change (e.g. how combining top-down authority and bottom-up clinical leadership can help sustain stakeholder participation and challenge local vested interests). Finally, we have shown how person-centred and team-centred leadership may influence the ways in which teams work together to deliver high-quality, safe care (e.g. effective chairing of meetings may support a greater shared sense of purpose, while engaging with and valuing team members as individuals may help build psychological safety). Box 6 provides a summary of the lessons that can be drawn from the evidence.