

1.1 Leadership in health and social care



Jackson and Parry (2018: n.p.) state that: "There are broadly five ways that one can go about studying leadership. You can actually attempt to lead, you can observe leadership in action, you can talk about leadership, you can read about it and you can write about it."

In this subject, you will definitely be doing the last four, and will hopefully have a chance to do the first as well.

Leadership is one of humankind's enduring preoccupations. What good leadership is and which people become leaders, as well as how, is endlessly fascinating, not least of all because leadership both good and bad has serious 'real-world' consequences.

We will consider both aspects of this question – what leadership is at an individual, team and organisational level. We will then go on to analyse, using real-world examples, the impact of leadership in health and social care services.

So what is leadership?

This is not as an easy a question to answer as you might have thought. Almost three decades ago Rost (1993) identified 221 definitions of leadership spread across 587 publications, and the leadership field has only expanded (exponentially) since then.

Definitions vary according to when the definition was written, the theoretical perspective of leadership used, and even the field or sector in which leadership is being discussed.

In the following weeks, we will look at leadership competencies, which will also give you an idea about the diversity inherent in this concept. In the context of healthcare, Dickinson and Tholl (2020: n.p.) state that:



"leadership is composed of taking initiative or going first and facing the risks that go with that; influence with and on people (through positional authority, character or wisdom); taking responsibility and pursuit of a shared purpose or goal (i.e., to produce quality in whatever endeavour is being pursued—products or service in private sector; peace, security, governance in public life; health and wellness in health care). They all feed into our definition of leadership in health: "Leadership is the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve."

What is the difference between leadership and management?

Peter Drucker [a key management theorist of the 21st century] :



“... notes that the major difference between a manager and a leader is that the manager focus on doing things right, while the leader focuses on doing the right things. This is not a simple play on words.” Cohen, quoting Drucker argues that “Of course you would like a leader who is both efficient (doing things right) and effective (doing the right things), but if it is a choice between the two, and this determines the focus, then the leader must focus on getting the right job done, at the expense of efficiency” (Cohen, 2009: 57)

What if anything is different about the leadership of health and social care?

As the current COVID19 crisis shows, leadership in health and social care is not the same as leadership in other industries. Yes, there are similarities and often there are core competencies that cut across sectors (which you will discover as you progress through this subject).

But both health and social care are very high stakes sectors – probably the highest if you consider that our work is literally about life and death, and about both caring for people at their most vulnerable (as individuals) and caring for the most vulnerable groups, and all of this under the scrutiny of governments, professional bodies, the media and the public in general.

As a health/social care manager, you will be expected to lead in good times and in times of crisis. There will be times when your leadership will make all the difference to the lives of both your patients/clients and your staff and colleagues.

1.2 If leadership is the answer, what is the question?

What is the question?

There is no doubt that there has been an explosion of interest in leadership over the last decade. Even a quick look at Google Scholar brings up over four-million results relating to leadership, and Medline has 12,856 references relating to leadership in the *title* of the document alone!

So why the interest in leadership, and why now?

There are many answers to that question, some of which we will continue to explore throughout this module. But for now, we are going to draw on three recent major inquiries into health and social care: the UK Francis Inquiry into the Mid-Staffordshire Hospital, the Australian Royal Commission into Aged Care Quality and Safety, and the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

The Francis Inquiry into Mid-Staffordshire Hospital

Read through the following slides on the case of the Francis Inquiry into the NHS Mid-Staffordshire Hospital. When you have finished reading the slides complete the activity below.

Leadership and the Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (RCACQS) was commissioned in 2019 to examine the "... quality of aged care services and whether those services are meeting the needs of the Australian community. This includes: care for older people living at home; people living with dementia, and; people living in residential aged care including younger people with disabilities" (The Royal Commission into Aged Care Quality and Safety, 2019: 1). To date, the Commission has produced multiple background papers and a three volume interim report. The final report is due on 26 February 2021.

Read through the following slides to discover more about some of the findings into the RCACQS.

The Royal Commission into Aged Care Quality and Safety



Aboriginal and Torres Strait Islander communities

A lack of leadership was also identified by representatives from Aboriginal and Torres Strait Islander communities. For example, one submission by Ms Malay argued that racism is a barrier to entering the aged-care workforce for Aboriginal and Torres Strait Islander peoples, noting that:



... we need current leadership in the sector to promote cultural safety, first, by working collaboratively with local Aboriginal traditional owners—owner groups to improve—to increase the two-way sharing. We need cultural leadership in the sector to promote cultural safety, firstly, by working together. We need employers to understand and respect Aboriginal employers' obligations such as attending sorry business and law business. (Royal Commission into Aged Care Quality and Safety, 2019a: 177).

The Interim report also concluded that there was a need for "... ongoing access to training and development on Country [for Aboriginal and Torres Strait Islander peoples] to sustain development and education, with a focus on supporting more Aboriginal and Torres Strait Islander people to move into management and leadership positions within aged care" (Royal Commission into Aged Care Quality and Safety, 2019a: 9).

The following slides touch upon the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Read the slides then complete the activity at the end of this page.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability



Start

1.3 Leadership theories



As we said in the introduction, leadership has held endless fascination for people around the globe for millennia.

What leadership is (and more importantly, 'good' leadership), as well as if and how it can be developed, have been the subject of much consideration, discussion and research.

As with many ideas (such as management) ideas about leadership have changed over the decades both because of societal changes (think for example of the different views about women as leaders over time) and changes in perspectives, frameworks and methods for studying leadership.


Earliest studies of leadership

As we said in the introduction to this subject, leadership has always been a subject of interest to human beings.

This is evident in the number and range of books written about leadership around the world, such as Machiavelli's works in Renaissance Italy (including *The Prince* written in 1513, which considered the political skills required by the new – non-hereditary – princes) and Sun Tzu's *The Art of War*, as well as the biographies of military leaders like Alexander the Great or Julius Cesar.

As Grint (2011: 3) dryly notes, "To a very large extent our knowledge of leadership in ancient times is crucially dependent upon the existence of written texts, and here lies the first lesson of leadership: history is written, generally speaking, by the winners." And as we will discuss in future weeks, it has been written mainly by men, and in the last century, by people in English-speaking countries.



Lambros Kazan. *Alexander The Great at Thessaloniki City, Greece* [Stock Image]. [FILE# 210492393](#)  .

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1.3.2 Traditional trait theories

Trait theories are among the earliest attempts (in the 1930s and 1940s) to study the answer to the question: 'What type of person makes a good leader?'

In other words, these theories aimed to explain distinctive characteristics associated with effective leadership. They were the study of the trait-based characteristics of people that make them suited to leadership, which traits indicated the difference between leaders and non-leaders, and effective and ineffective leadership.

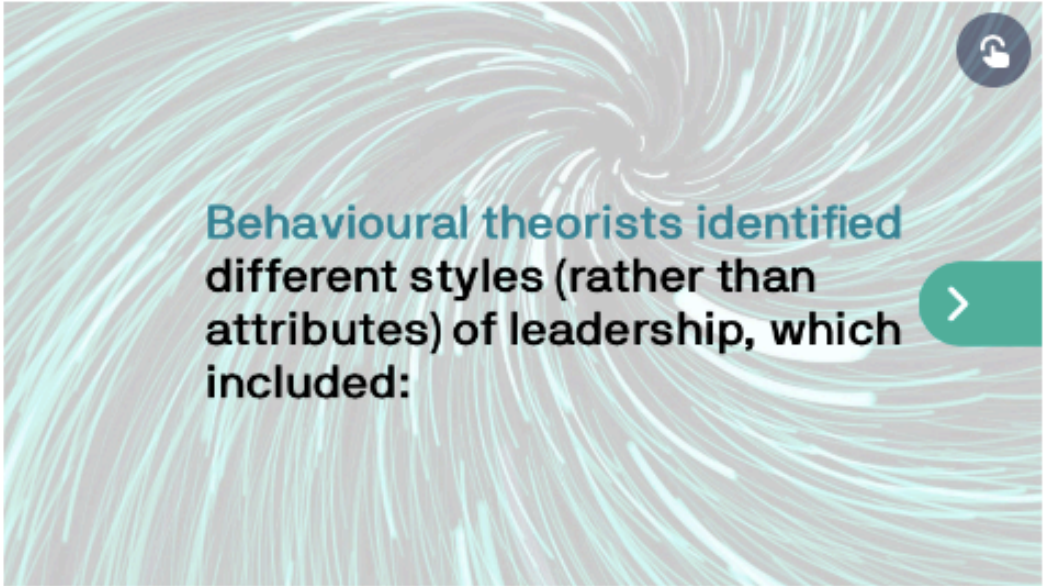
1.3.3 Behavioural leadership theories

The limitations of trait studies (including the failure to identify universal leadership traits) led to behavioural theories of leadership that emerged in the 1940s and 1950s, and became known as the 'behavioural school' of psychology (e.g. Skinner's work).


Whereas trait theories considered the innate characteristics of leaders, behavioural theories consider leadership a behaviour – answering the question of 'What does a good leader do?' rather than 'What is a good leader?'

These theories are similar to trait theories in that they also focus on what makes a leader effective. However, instead of examining the leaders' personalities, they examined the leaders' behaviours, which by implication, could both be learnt and enhanced.

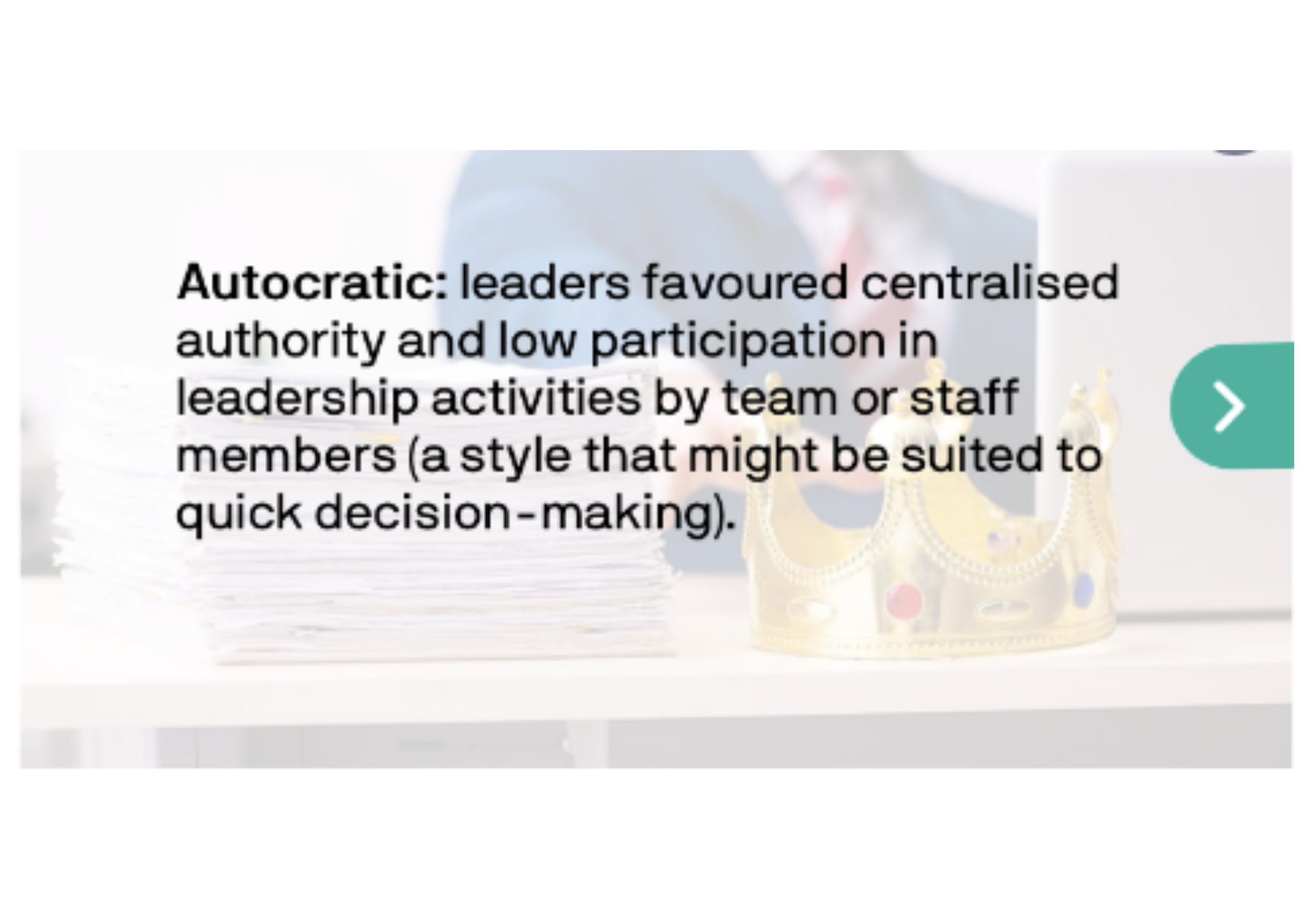
These studies were led by universities and researchers in the U.S., including Ohio State University, the University of Michigan and the University of Iowa. Key researchers included people like Kurt Lewin and Douglas McGregor (who developed Theory X and Theory Y).



Behavioural theorists identified different styles (rather than attributes) of leadership, which included:




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A blurred background image of a person in a suit sitting at a desk with a stack of papers and a gold crown.

Autocratic: leaders favoured centralised authority and low participation in leadership activities by team or staff members (a style that might be suited to quick decision-making).





Democratic: high involvement of team or staff members, high participation, constant feedback from the leader to their team (important when team agreement matters).

Laissez faire: leader essentially takes a 'hands-off' approach to leadership and management.



There were also a number of frameworks or grids of leadership developed, including that by Blake and Mouton (1978), which divided leadership behaviours into concern for people and concern for production. These grids divided leadership styles where there was high concern for people into 'country club management' and 'team management', in contrast to middle-of-the-road management and leadership styles that had a lower focus on people, which were labelled 'impoverished management' and 'authority compliance management'.

1.3.4 Situational or contingency theories

With the realisation that there may not be a single best leadership style for all contexts or situations, the 1960s saw an increased interest in what came to be known as 'situational' or 'contingency' theories.

These theories considered not just the abilities of the leaders, but the leaders (including their individual leadership styles, traits, behaviours, roles and positions), the situation (i.e. the type of work people were involved in, the systems and structures of the organisation, and the environment in which it was undertaken) and the characteristics of the 'followers' (including maturity, training, needs and cohesiveness).

1.3.5 Power and influence theories

The last of the classical theories we will be considering is that of charismatic leadership, which is also known as 'inspirational' or 'visionary' leadership.

Power and influence theories



Start



Max Weber

Charismatic leadership was studied as far back as the late 1800s by theorists like Max Weber, who identified three types of authority in society:

- ⚙️ the traditional
- ⚙️ the rational-legal
- ⚙️ the charismatic



1930s and 1940s

For obvious reasons, as people considered what made populations follow the leadership of mass murders like Hitler or Mussolini.



1980s

A resurgence in the interest in charismatic leadership began in the mid 1980s as part of the 'new leadership' approaches (more of which we will consider later in this module).

The study of charismatic leadership is rooted, as Denis, Kisfalvi, Langley, and Rouleau (2011: 75) claim, in the the "heroic tradition" of leadership studies, which sees



leaders as exceptionally gifted individuals exercising magnetism and power over others and uniting them in a higher purpose



...

1980s

Despite this history, Bryman, Collinson, Grint, Jackson, and Uhl-Bien (2011: xiv) argue that:



Significantly more research and theory building are required, especially to deepen our understanding of the interaction effects between context and charismatic leadership, institutionalization and succession dynamics, and the liabilities of this important form of leadership.



Recent studies

What is known is that like contingency theories that precede it, recent studies of charismatic or inspirational leadership focus on:



... leader effectiveness; subordinate effectiveness; subordinate satisfaction; and subordinate commitment

(Bryman, 2011: 24)

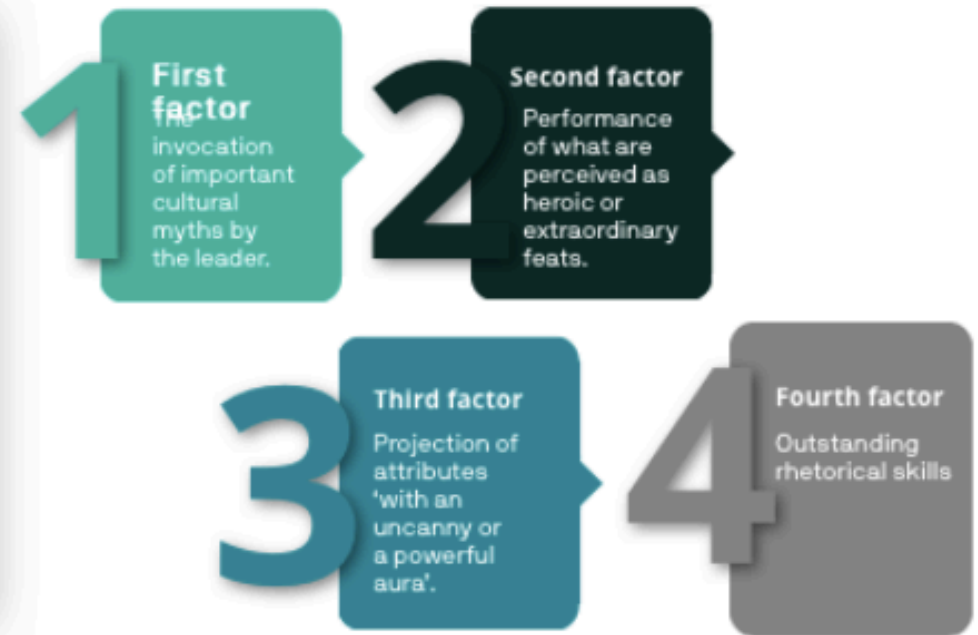


The charismatic leader

We also know that there is a "... tendency to associate outstanding leadership with charismatic or transformational leaders" (Bryman, 2011: 23).

Willner identified four factors that, aided by personality, appear to be catalytic in the attribution of charisma to a leader:

(Conger, 2011: 86; Willner, 1985).



Behaviours of charismatic leaders

Drawing on current research, Northouse identified five behaviours of charismatic leaders. Charismatic leadership is characterised by leaders who:

1. Serve as strong role models for the values that they desire others to adopt.



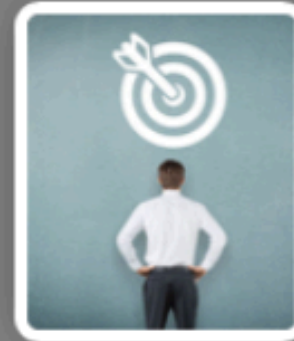
2. Show competence in every aspect of leadership, so others trust their decisions.



3. Articulate clear goals and strong values.



4. Communicate high expectations for followers and show confidence in their abilities to meet those expectations.



5. Are an inspiration to others. They can excite and motivate others to become involved in real change.



(Northouse, 2021: n.p.)

1.4 New approaches to leadership

Newer leadership theories

As the fascination with leadership increased in recent decades, a new set of leadership theories have emerged.

In this section we will consider a number of these:

- transformational leadership
- authentic leadership
- distributed/systems leadership
- servant leadership
- followership.

The latest leadership theories acknowledge that “... leadership is no longer simply described as an individual characteristic or difference, but rather is depicted as dyadic, shared, relational, strategic, global and a complex social dynamic” (Avolio, Walumbwa & Weber, 2009: 422-423).



1.4.1 Transformational leadership

Transformational leadership has been described as “one of the current and most popular approaches to leadership that has been the focus of much research since the early 1980s” (Northouse, 2021: n.p.) and as one of the “most important approaches for understanding and influencing employee effectiveness” (Cleavenger & Munyon, 2013: 351).

1.4.2 Authentic leadership

Authentic leadership theories examine the way in which leadership attributes are based on the core values and beliefs of the leader, the degree to which leaders remain true to themselves, and whether their leadership is genuine and 'real' (Avolio et al., 1991).


Definition

Malila, Lunkka and Suhonen (2018: 129) define authentic leadership as "... a leader's non-authoritarian ... ethical and transparent behaviour pattern ... which can be seen as the basis and core of all positive leadership forms".



Authentic leadership
is



- 
- **intrapersonal (focusing closely on what is going on within the leader, including their self knowledge)**
 - **interpersonal (a form of leadership which is created collectively by leaders and followers)**
 - **and developmental (something which can be nurtured within leaders, rather than a fixed trait).**

(Northouse, 2021)



RaleighThreeShips. *Photo of Bill George.*

Authentic leadership attributes include whether a leader is able to:

- enact their true selves in the workplace by being honest with themselves
- be sincere with staff and colleagues
- behave in a way that reflects their personal values.

Bill George, one of the developers of the authentic leadership approach, argues that authentic leaders have five main attributes which are displayed in various ways (George, 2003):

1. purpose (passion)
2. values (behaviour)
3. relationships (connectedness)
4. self-discipline (consistency)
5. heart (compassion).



RaleighThreeShips. *Photo of Bill George.*

[Wikipedia](#) 

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A systematic review of authentic leadership in health care by Alilyyani, Wong and Cummings (2018) indicated that studies showed it was positively associated with positive staff outcomes such as psychological wellbeing, satisfaction with work, health, wellbeing and performance, and a reduction in falls in patients.

1.4.3 Distributed (shared) or systems leadership

Distributed leadership has been of increasing interest in the health and social care sectors. A simple way of understanding distributed leadership is the idea of shared leadership, where the focus is not on one main leader at the 'top' of the organisation but rather on mobilising leadership at all levels of an organisation. Avolio et al. (2009: 431) note that Pearce and Conger's (2003) definition of distributed leadership is the most cited:



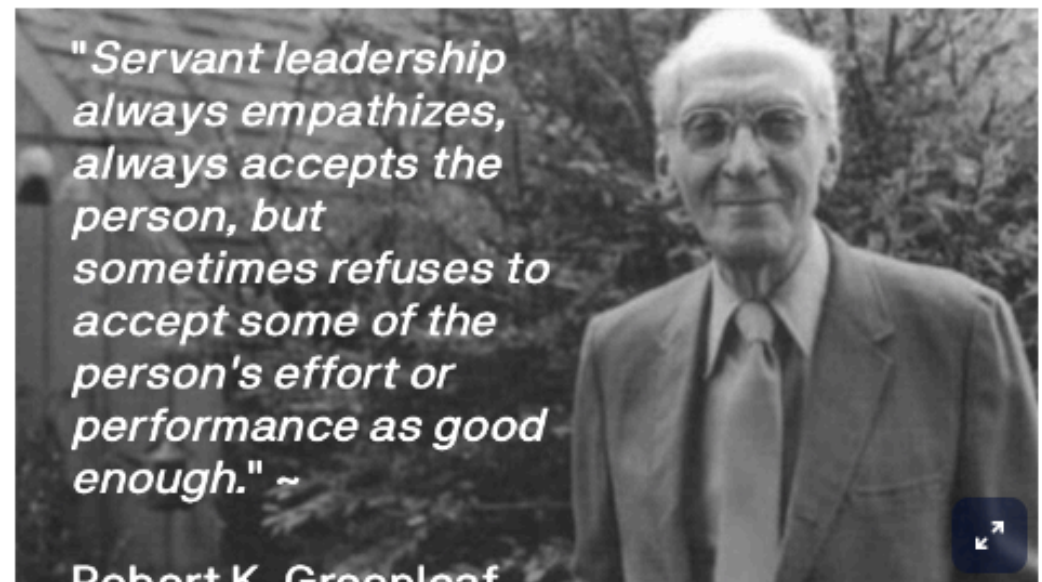
“a dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals or both. This influence process often involves peer, or lateral, influence and at other times involves upward or downward hierarchical influence ... Although a number of authors [beginning with Mary Parker Follett (1924)] have discussed the idea of shared leadership, it has only gained attention in the academic leadership literature recently, and relatively few studies have tried to measure shared leadership.”

1.4.4 Servant leadership

The idea of servant leadership was posited by Robert Greenleaf, a 20th-century researcher who was sceptical about the effectiveness of authoritarian relationships between employers and employees.

Trastek, Hamilton and Niles (2014: 374) argued that "... servant leadership [is] the best model for health care organizations because it focuses on the strength of the team, developing trust and serving the needs of patients."

A servant leader is essentially a steward whose role is to empower others to become better at what they do. Servant leaders use authority to influence and persuade rather than power to enforce their objectives and organisational goals.



Van Dierendonck (2011: 1228) argues that:



"Servant leadership is demonstrated by empowering and developing people; by expressing humility, authenticity, interpersonal acceptance, and stewardship; and by providing direction." Schwartz and Tumbler (2002: 1424) argue that "... servant leaders grasp that the relationship between leader and follower is a mutual search for wholeness. The servant leader understands that the first step to leading others is the necessity to change oneself."

1.4.5 Followership

One emerging area of interest in the study of leadership is the role of followers. One definition of leadership is that a leader is a person with a vision and *followers*.

The study of the role of followers in leadership recognises that, because leadership is not only about organisational position, people might lead in some contexts or situations within an organisation, and be followers in other contexts.

Uhl-Bien, Riggio, Lowe and Carsten (2014) identified two types of followership:

1. role-based (relating to formal or informal positions in hierarchical systems)
2. relationship-based.



Northouse (2021: n.p.) defines followership as the:



"... process whereby an individual or individuals accept the influence of others to accomplish a common goal". As part of this process "typically, followers comply with the directions of wishes of leaders – they defer to leaders' power". He goes on to note: "Like leadership, followership is not amoral: that is, it is not a process that is morally neutral. Followership carries with it a responsibility to consider the morality of one's actions and the rightness or wrongness of the outcomes of what one does as a follower."

Followership theory



Start

Mary Parker Follett

A management theorist and creator of the idea of 'win-win' approaches to conflict resolution was also interested in the role of followers in the 1920s (Follett, 1949/2013).

Her vision for management, and leadership, was that it should involve "power with" and not "power over" (Melé & Rosanas, 2003).



Crossman and Crossman

More recently, in their review of the literature on followership Crossman and Crossman (2011) developed both a typology of followership behaviours and a reported Thody's typology of positive and negative follower behaviours which includes roles played by followers such as toxic creator or toxic handler (Thody, 2003).



1980s

Srinivasan and Holsinger (2012) talk about followership in terms of the yin and yang of leadership – both aspects are required for the effective functioning of organisations.

They quote Howard Koh who as the Assistant Secretary for Health of the United States Department of Health and Human Services, who argued that:



In a stark contrast, then, to some classic leadership models portraying bold leaders directing passive followers, the public health culture favors a more collaborative, facilitative leadership that recognizes the value of complementary and synergistic leadership functions among multiple contributors



(Srinivasan & Holsinger, 2012: 97)

