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[Leading, Managing, Caring: understanding leadership and management in health and social care]

by Sara Mackian & Joan Simons

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Understanding leadership and management in health and social care

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Chapter 3 Leadership and vision

Joan Simons and Helen Lomax

3.1 Introduction



Figure 3.1 'A leader is one who knows the way, goes the way and shows the way' (Maxwell, 2007, quoted in Dempsey and Forst, 2007, p. 72)

Leadership is increasingly defined within theory and policy as an activity which is central to all staff at all levels, and one which is increasingly allied to the modernisation and transformation of health and social care services. For Max Landsberg (2002), the essence of leadership is the ability to create vision, inspiration and momentum in a group of people. This chapter therefore builds on the discussion about contemporary management in Chapter 2, by exploring the relationships between leadership and vision and what they mean for managers, aspiring managers and practitioners in health and social care.

The imperative to transform and improve services reflects recent developments in leadership theory. There is a growing belief that the potential for leadership can be developed in a range of people and distributed throughout organisations, thereby fostering collaborative and integrative working to inform and contribute to an overall organisational vision (Ferlie and Shortell, 2001). This is mirrored in health and social care strategy in which the importance of identifying, nurturing and promoting talent and leadership at all levels is increasingly prioritised (Botting, 2011).

This chapter reviews historical and current leadership theories and explores the challenges in applying them to health and social care. It addresses the following core questions.

- How is leadership defined?
- What influence does vision have in effective leadership?
- What are the different leadership theories relevant to working in health and social care?
- How can leaders adapt their leadership style to meet the needs of different situations?

3.2 Defining leadership



Figure 3.2 What is leadership?

This section addresses the question what is leadership (Figure 3.2). Hartley and Allison (2003) explore the role of leadership in the context of the modernisation and improvement of health and social care services. In defining leadership, they distinguish between three different aspects: the person, the position, and the processes. Research has often focused on the characteristics, behaviours, skills and styles of leaders as people and the role of individuals in shaping events and circumstances. However, Hartley and Allison's 'three Ps' stress the importance of wider contextual awareness as well (one of the basic building blocks of caring leadership and management). Rogers and Reynolds (2003) added a fourth P – purpose – a reminder that goal awareness is also essential.

The attributes of person, position, process and purpose are useful when thinking critically about how leadership models operate in practice, including the limitations of single category explanations. They also encourage more critical thinking and dispel notions of leadership based on the characteristics or personality traits of the individual; for example, the idea that someone is a ‘born leader’ (Rogers and Reynolds, 2003). Similarly, a singular emphasis on ‘position’ ignores the influence that those without formal office may exert while overemphasising the authority of high office (which does not in itself guarantee leadership). Rather, in order to understand how leadership models operate in practice, it is more useful to think about the ways in which the characteristics of the ‘person’ and ‘position’ intersect with the ‘process’ (collaborative work with individuals, groups and organisations) and the contribution of the underlying strategic values, vision and objective (‘purpose’) (Table 3.1).

Table 3.1 The ‘four Ps’ of leadership

Leadership aspect	Focus
Person (character)	The character, behaviour, skill and interpersonal style (e.g. charismatic, controlling, supportive, aloof)
Position (role)	The office held (e.g. chief executive, senior manager, no formal position)
Process (how)	How leaders work with individuals, groups and organisations to find solutions to problems
Purpose (vision)	The contribution of the underlying strategic values, vision and objective

The four Ps help in understanding leadership as a set of processes which occur between and across individuals, groups and organisations. The role of the leader in relation to these processes is not to have exceptional capacity to provide solutions to problems. Instead, it is to work with other people ‘to find workable ways of dealing with issues for which there may be no known or set solutions’ (Hartley and Allison, 2003, p. 298). Case study 3.1 gives you an opportunity to consider these different aspects from the perspective of a social worker.

Case study 3.1: A manager who demonstrated the four Ps of leadership

Sheila articulated what we were there for. She put the clients first. She allocated work openly, allowing team members to work to their strengths. Sheila was nice and polite but firm, with a transparent strategy that had a client focus. She led from the inside, not from on high. She was part of the team, but there was never any doubt that she had the authority of a manager and she wasn't frightened to use her authority.

Her manner was pleasant and she treated people with respect. Good practice has much to do with respect for the client group and the knock-on effect for workers. Sheila was a good communicator, positively or negatively, and always dealt with people straight, not behind their backs. She gave good feedback.

Sheila had personal authority that came from her behaviour as well as her professional expertise. She also had the authority of her position. She demonstrated many characteristics that enabled her to build trust and commitment in her staff. She modelled integrity, respect and care.

(Based on Rogers and Reynolds, 2003, pp. 58–9)

The description of Sheila infuses the different aspects of leadership with a sense of a particular style of doing things that is rooted in the values of health and social care services. Sheila the person is described as nice, polite, a good communicator, reliable, while at the same time being firm and always dealing with people 'straight'. These characteristics underpinned Sheila's role or position. She is described as having personal authority that came from her behaviour as well as her professional expertise and the authority of her role. In relation to the last two Ps – process and purpose – Sheila clearly worked effectively with her staff to find solutions to problems.

The 'four Ps' provide a comprehensive way of thinking about leadership in action, and they reflect the four building blocks of a fully rounded, caring manager which were introduced in Chapter 1 as the foundation to effective leadership and management in health and social care. However, in the past, leadership has not always been understood in such a holistic context. The next section provides a backdrop to the

current view of leadership by exploring the historical development of leadership theory.

3.3 A historical perspective of leadership theories

The trait approach developed by Stogdill between 1949 and 1970 was one of the earliest and most influential attempts to develop a theory of leadership (Stogdill, 1974). This approach to theorising leadership is often called the ‘great man theory’ as it focused on describing the innate qualities of a ‘great man’ who was a great leader. This approach suggested that the following traits are essential to be a great leader and, furthermore, that the person is born with them (Northouse, 2010, pp. 20–1):

- intelligence
- self-confidence
- integrity
- sociability
- determination.

It is not surprising that such a theory held sway in the first half of the 20th century as there are many examples of great men who did possess such traits. One was the Indian nationalist leader Mahatma Gandhi, who was seen as an inspirational leader (Figure 3.3).



Figure 3.3 Mahatma Gandhi (1869–1948): one of the ‘great men’

These 'great men' theories developed from the study of the lives of prominent people (invariably men) throughout history. Common traits were identified, many of which might still be used to describe contemporary leaders in popular ideas about what makes a good leader; for example, judgement, decisiveness, adaptability, alertness, confidence and integrity (Marquis and Huston, 2009).

Although it is still commonly accepted that the traits listed above are important requisites of successful leadership, it has been acknowledged that a person does not have to be born with these traits to be a leader, as they are skills that can be learned or acquired. In the case study above, Sheila clearly exemplifies many of the traits of a great leader; however, these are only one dimension of the leadership skills which enable her to lead effectively. She is also adaptable and creative in her approach to a constantly shifting health and social care landscape. In other words, as Sheila's leadership style exemplifies, a model of leadership based on traits alone fails to take account of the leader's situation and the need to be adaptable as a leader.

In response to trait theory, Katz (1955) developed an alternative leadership approach, focusing on skills which could be taught, as opposed to traits which were considered innate and fixed in an individual. By taking this approach, another era in leadership theory emerged, opening up the possibility that leaders could be developed. Katz (1955) suggested that skills are what leaders can accomplish whereas traits are what leaders are. The skills approach led to studies of skills for leadership, and the development of programmes of study which allowed students of leadership to engage in developing the necessary skills of leadership, such as persuasion, communication, decision making, teamworking, planning, vision and strategy.

Both trait and skill theories of leadership have their limitations because they do not include how the leader acts, or how they engage in leadership in practice with others. In the 1980s, several American studies explored different styles of leadership and how leaders act (Blake and Mouton, 1985). The main focus of this approach suggested that leaders engage in two primary behaviours: task behaviours and relationship behaviours. Blake and Mouton suggested, therefore, that there are two extremes of leadership concern: concern for results and concern for people. The leader who is concerned mainly with results cares little about people and operates in fear of something going wrong. In health and social care, such a leader would be focused on meeting targets, at the expense of their staff or service users. The other extreme

of leadership concern is concern for people, where the leader cares little about results and operates entirely from a desire to be popular and approved of. In health and social care, such a leadership style would be ineffective, as a balanced approach to leadership, focusing on both results and people, is fundamental to the successful operation of any team.

Think about a leader you admire. Do they focus on people, results, or a mixture of both?



Clearly, a successful leader who manages to focus on people as well as results needs to wield a degree of power to influence both. Another perspective on leadership behaviour is, therefore, to look at the power that a leader might exert over their followers in a team. Three styles of behaviour can be plotted on a continuum, according to the type of power a leader might exert (Figure 3.4).



Figure 3.4 Styles of leadership behaviour

The autocratic leader exercises ultimate power in decision making and controls the rewards and punishments for the followers in conforming to their decisions. This type of leader is dictatorial and all-powerful. The democratic leader encourages all members of the team to interact and to contribute to the decision-making process. This leadership style shares the power between the leader and their followers. Sheila, in the earlier case study, is an example of a democratic leader. The laissez-faire leader deliberately decides to pass the focus of power to the followers. However, it is important to note that this style is distinct from 'non-leadership' when the leader refuses to make any decisions (Barr and Dowding, 2008).



Recalling Wong’s web of power in Chapter 1 (which comprises power-from-within, power-to, power-over and power-with), what types of power are in evidence for these three behaviour styles?

You can see from this brief overview of three historical approaches to leadership theory (trait, skill and style of behaviour) that the focus of leadership theories has evolved from an approach focused on a clearly identifiable leader born with innate abilities, to one who can be developed with appropriate skills and training, depending on the needs of the organisation.

As any leader needs to be able to influence other people, they will benefit from an understanding of the way power operates around them. They may be laissez-faire and prefer others to develop their own power-from-within, or they may be autocratic and prefer to have power over others. Above all, an awareness of the different traits, skills and styles of leadership is important for anyone interested in developing their own capacity to lead (Table 3.2).

Table 3.2 Summary of leadership traits, skills and style or behaviour

Leadership traits (What you have as an individual)	Intelligence Self-confidence Integrity Sociability Determination
Leadership skills (What you can learn to become an effective leader)	Vision/strategy Communication Persuasion Adaptability Teamwork Decision making Planning
Leadership style or behaviour (How you operate as a leader)	Results focused Person focused Autocratic Democratic Laissez-faire

What are the similarities between the leadership traits identified in Table 3.2 and the traits expected of a professional working in health and social care?



As well as being aware of the different styles of leadership, the rapidly changing context of health and social care means that leaders must anticipate and be responsive to new policies and initiatives that impact on how they work. In doing so, they need to approach leadership as a collective endeavour to which all members of a team can contribute in order to achieve the organisation's vision.

3.4 Leadership and the place of vision



Figure 3.5 What does 'vision' look like?

Leadership is fundamentally about handling constant change, creating a vision (Figure 3.5), and engaging individuals in dealing with ever-changing situations while working towards that vision (Alban-Metcalfe and Alimo-Metcalfe, 2009). Most of the literature on vision suggests that it is a component of leadership that motivates people to higher levels of effort and performance. However, the vision of an organisation needs to be communicated to all levels of the workforce in order for this to happen. And there lies the challenge of having a vision that can apply throughout an organisation. Visions of exemplary transformational leaders are often highly inspirational, optimistic and future-oriented.

Conger and Kanungo (1998, p. 147) suggest that vision involves idealised goals, established by the leaders, representing a perspective shared by followers. Alongside this definition should be added a view of the future, so that the vision provides the direction to be followed. Most

organisations have a 'vision statement'; the role of the leader is to motivate their team to align themselves with the vision statement and clearly articulate how they will achieve the vision.

So what does a vision do? The purpose of a vision is to clarify a set of ideals, and/or articulate a sense of purpose. However, many organisations work without aligning themselves to a vision, or they may have a formal vision statement that is not well communicated to their staff. Visionary leadership can positively affect motivation and wellbeing, leading to a sense of fulfilment, and a reduction in job-related stress, and creating a strong sense of team effectiveness (Strange and Mumford, 2005). But, as with any leadership tool, a vision will only be effective if it is done right, and the likelihood of success of a vision statement depends on the vision containing several characteristics:

- brevity
- clarity
- abstract and challenging
- states the organisation's purpose
- future focused
- sets a desirable goal
- matches the organisation's success measures.

(Kirkpatrick, 2008)

With an effective vision, everyone knows what they are doing and why they are doing it. Working in health and social care, a unit that is working towards a well-defined and well-communicated vision will create safer practice environments for, and enhance the quality of, care for service users (see Box 3.1).

Box 3.1: Examples of vision statements

That all children with brain injuries, multiple disabilities and complex health needs have the opportunity to live the best life possible.

(The Children's Trust, 2012)

Our vision is an ambulance service for people in Scotland which is delivering the best patient care whenever and wherever it is needed.

(Scottish Ambulance Service, 2012)

Looking at these two vision statements, although they are just over 20 words long, they are clear, challenging and focused on their organisation's future ideal state. The challenge for each service, if it wants to be successful in meeting its vision, is to put in place the necessary leadership to motivate staff.

The Work Foundation (2010, cited in NSASC, 2011) suggests that outstanding leaders focus on aligning people emotionally to a vision and aligning the needs of 'now' with a vision of the future. Adair's functional model of leadership embraces the mobilisation of vision as a central focus.

Adair's model of action-centred leadership

John Adair developed a model of leadership based on three overlapping circles, to represent what he suggests are three distinctive, but interrelated, areas involved in every leadership situation. As Box 3.2 shows, these carefully delineate the needs of individuals from those of the group and task. While, as Figure 3.6 illustrates, these may converge in different ways, they may also be quite separate and, indeed, may conflict. A successful leader will be skilled at identifying what these needs are and where they converge or conflict.

Box 3.2: A model of leadership based on needs

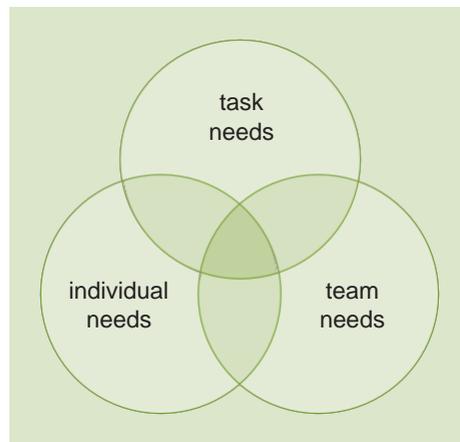


Figure 3.6 Adair's model of leadership (based on Adair, 2002, p. 76)

Task needs The difference between a team and a random group of people is that a team has a common purpose, goal or objective. If a work team does not achieve the required result or a meaningful result, it will become frustrated. Organisations have a core task: to provide a service, to make a profit, or even to survive. Achieving objectives is a major criterion of success for a leader.

Team needs In order to achieve these objectives, the team needs to be held together. Each person needs to be working in a coordinated fashion in the same direction. Effective teamwork will ensure that the contribution of the team is greater than the sum of its parts. Conflict within the team must be used effectively: disagreements can be productive and lead to new ideas, or they can be unproductive, creating tension and a lack of cooperation (see Chapter 7 for more on managing teams).

Individual needs Within working teams, individuals also have their own set of needs. They need to know what their responsibilities are and how well they are performing. They need an opportunity to demonstrate their potential and take on responsibility, and they need to receive recognition for good work (Adair, 2002, 2007).

How does Adair's model of leadership fit with the four building blocks of the fully rounded manager: personal awareness, team awareness, goal awareness and contextual awareness?



The next case study describes the journey of a nurse as she developed her leadership skills over time in a way which reflected a growing awareness of Adair's three areas.

Case study 3.2: Maz's leadership journey

Looking back now, I cringe at how ill prepared I was for my first role as leader in charge of a children's ward. As a student nurse, I had been taught an entirely task-oriented approach to 'get the job done'. As a newly qualified and inexperienced nurse, I applied the same sort of practices – it did not make me popular.

I had no appreciation of the needs of the individual or that we should have been working towards a common goal as a team. One member of staff, who wasn't happy with how I had allocated the responsibilities on a night shift, told me I was like Hitler! I left that job believing I didn't have what it takes to be an effective leader.

Many years later, I became the subject lead for a team of 18 lecturers. I struggled with not being able to say just how I felt if something was wrong. I needed to develop my emotional intelligence. However, by getting to know my new team and their individual preferences for how they liked to work, I realised that there are many ways of achieving a goal and my way might not be the best way. It was more important to harness my team's motivation in working towards a common goal and achieving the department's vision.

By letting my team know that I trusted and respected them as individuals, we were able to work together towards a common goal.

See Chapter 2 for more about emotional intelligence.

Clearly, over time, Maz developed her leadership role with some success. What gradually evolved through an eagerness to 'get it right' was an alignment with Adair's three distinct areas involved in a leadership situation.

According to Adair's model, the leader's role is to be aware of, and to manage, the tensions between the various needs as a result of the frequent conflicts between them. This demands a 'functional' approach to leadership that requires the leader to define the task, plan, evaluate, motivate, organise, and set an example. If, for instance, the leader of a unit, ward or nursing home concentrates all their efforts on the task of maximising the numbers of people admitted to it, while neglecting the training, encouragement and motivation of the staff members, there may well be short-term gains. However, over time, team members are likely to lose motivation and make less effort than they are capable of, which will, in turn, have a negative impact on outcomes.

Similarly, if a leader concentrates only on creating a team spirit and neglects the needs of specific individuals and the overall objective that the team needs to achieve, then maximum performance (as measured by intended outcomes) is unlikely. For example, certain individuals may feel that their personal contribution to the overall success of the team is not being acknowledged. If you have ever experienced some of these issues in your workplace, you may have been left with the feeling that a balance has not been achieved between the task, the team and the individual worker.



Looking back to the case studies above, can you identify a leader you know who has a leadership style similar to either Sheila or Maz?

3.5 Leadership theories that influence practice today

You have probably realised as this chapter progresses that approaches to modelling and theorising leadership are numerous and varied. This section explores some of the dominant approaches today and reflects on how they relate to the four basic building blocks of a caring approach to management and leadership.

Transformational and transactional approaches to leadership

James MacGregor Burns first used the term ‘transformational leadership’ in 1978 in his book *Leadership*. Burns believed that transformational leadership was about the fulfilment of ‘higher-order’ needs and the creation of a cycle of rising aspirations, with both the leader and the people being led ultimately being literally ‘transformed’ as individuals in the process of achieving their vision. Transformational leadership was seen as creating a sense of justice, loyalty and trust.

Bass suggests that ‘Charisma is a necessary ingredient of transformational leadership’ (1985, p. 31), and many commentators see charismatic and transformational leadership as interchangeable (for example, Rafferty, 1993). However, Bass (1985) goes on to say charisma alone ‘is not sufficient to account for the transformational process’. Bass and Avolio (1990) identify charisma, or ‘idealised influence’, as only one of four behavioural components of transformational leadership: charisma, intellectual stimulation, individualised consideration, and inspirational motivation. According to this view, ‘charisma is a separate component and is defined in terms of both the leader’s behaviour (such as articulating a mission) and the followers’ reactions (such as trust in the leader’s ability)’ (Conger and Kanungo, 1998, p. 14).

‘The result of transforming leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents’ (Burns, 1978, p. 4).

Recalling the first case study in this chapter, which qualities of transformational leadership did Sheila display?



Transformational leadership is sometimes considered to be an ‘ideal’ of leadership that goes beyond a simple question of charisma. However, it is also important to understand the context in which the leader is operating. The idea of transactional leadership helps to develop this.

Transactional leadership

Bernard Bass developed the notion of transactional leadership between the 1960s and 1980s, based on the idea of a contract process between the leader and the group. Bass (1985) suggests that transactional leadership includes the following characteristics:

- rewards and incentives to influence motivation
- an ability of the leader to monitor and correct followers in order to work effectively
- an explicit promise of tangible benefits for followers
- an ideological appeal.

This approach particularly suited the National Health Service (NHS) at the time, when the drive for more efficiency was first being formally introduced. It was felt that leaders and groups found mutual satisfaction with these transactional relationships, 'knowing where they stood' (Barr and Dowding, 2008).

The idea was developed and Marquis and Huston (2009, p. 42) identified the following characteristics of a transactional leader:

- focuses on management tasks
- acts as a caretaker
- uses trade-offs to meet goals
- examines causes
- uses rewards.

This list may be more 'managerial' in style than the sort of creative leadership we might expect in health and social care today. While a culture of following the rules has been found to be effective, especially where planning, organising and budget management are essential, Barr and Dowding (2008) suggest that transactional leadership has limited value where creativity is needed to deal with today's more complex organisations. It would appear, therefore, that transactional and transformational leadership both have a place as, in some ways, they complement each other, in the same way as leadership and management complement each other.

Applied leadership

In response to the plethora of theories on leadership, and the increasing political prioritisation of leadership, many organisations have looked inwards in order to identify their best leaders and understand what

makes them effective. The National Skills Academy for Social Care published *Outstanding Leadership in Social Care* in 2011, the first document of its kind to provide a framework of three key principles that they suggest underpin outstanding leadership.

- 1 Thinking and acting systematically on behalf of the organisation.
- 2 People are the route to performance.
- 3 Leaders achieve through their impact on others.

These three principles were developed from a study by The Work Foundation (2010, cited in NSASC, 2011), which found that the highest-performing leaders shared a style of leadership that engaged and enabled their people to achieve more than they thought possible. This style of leadership can be broken down into nine broad themes (see Box 3.3).

Box 3.3: Characteristics of high-performing leaders

Outstanding leaders:

- 1 Think systematically and act long term.
- 2 Bring meaning to life.
- 3 Apply the spirit, not the letter of the law.
- 4 Are self-aware and authentic to leadership first, their own needs second.
- 5 Understand that talk is work.
- 6 Give time and space to others.
- 7 Grow people through performance.
- 8 Put 'we' before 'me'.
- 9 Take deeper breaths and hold them longer.

How might the themes in Box 3.3 support a leader who is trying to motivate a team around a particular vision?



Relationships with other people are a key part of leadership (team awareness). However, it is equally important to understand the context or situation in which the leader leads (contextual awareness). The next section therefore explores situational leadership theory.

Situational leadership theory

I expect them to provide leadership to their teams. I expect them to understand and feel personally accountable in their positions of seniority. I expect them to be able to really model themselves on how I want leadership to look but in their leadership style they would be giving out messages that are absolutely consistent with the ones that we are working on together so that there is a coherence through the organisation.

(Social care leader, quoted in NSASC, 2011, p. 80)

For some time, it was assumed that leaders could be matched with one of the textbook leadership styles – and that each leader would always use the same style. Research since the 1970s challenged this view, recognising that many leaders' styles could not be so emphatically identified (Goleman, 2000). Rather than being located in convenient boxes or categories, many leadership styles are more likely to be positioned somewhere on a continuum between authoritarian and laissez-faire (Barr and Dowding, 2008). In Maz's case, the development of her leadership style could be seen to move from a dictatorial authoritarian style towards a more facilitative approach that was matched to the situation she was dealing with.

Effective leaders respond to each new challenge by adjusting their style according to the situation, recognising that greater attention needs to be paid to the context in which both leaders and followers operate. This was acknowledged in Hersey and Blanchard's theory of situational leadership (see Box 3.4). This was formulated in the 1960s and has continued to evolve in response to the shifting social, economic and political context in which leaders operate (Hersey et al., 2008). Another contributor to the development of situational theory, also known as contingency theory, is Fiedler (1967). He proposed that exploring the relationship between an individual's personal style and the conditions found in the workplace can predict an individual's performance.

Box 3.4: A theory of situational leadership

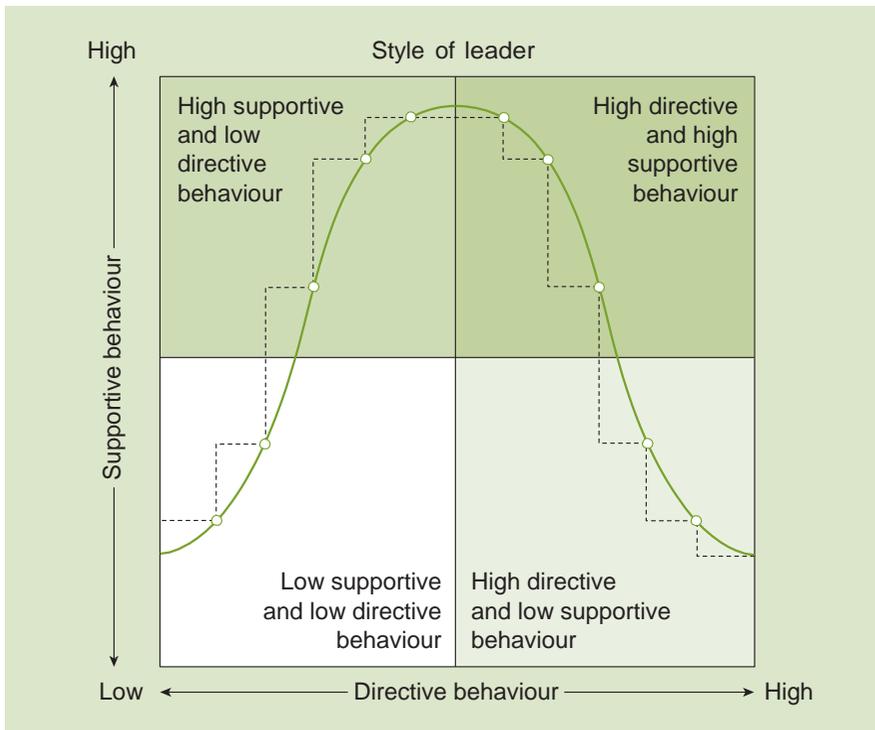


Figure 3.7 Situational leadership (Blanchard et al., 1986, p. 74)

A high directive/low supportive approach is appropriate for staff who have high commitment but low competence. This is a relationship that focuses on instruction.

A high directive/high supportive approach may be more effective with staff who have some competence but reduced motivation to accomplish the task. Leader behaviours include coaching, giving encouragement and asking for input. However, the final decision about what the aims and outcomes should be, and how to accomplish them, remains with the leader.

A high supportive/low directive approach is for staff who have competence but low commitment. This approach involves listening, praising, asking for input and giving feedback. Staff have control over day-to-day decisions, but the leader is available to help with problem solving.

A low supportive/low directive approach is most effective with staff who have a high degree of commitment and competence. After agreeing what is to be done, the leader lessens involvement in planning and day-to-day details and even intervenes less with support.

(Rogers and Reynolds, 2003, pp. 65–6)

In Figure 3.7, the leadership style changes from ‘directing’ to ‘coaching’ (see Chapter 10 for more on coaching), to ‘supporting’, and eventually ‘delegating’ as staff performance improves. This theory of situational leadership has considerable intuitive appeal, and has been used by numerous organisations, including major companies such as Xerox, IBM and Mobil Oil (Robbins and Judge, 2009). According to Manthey (1994), it is said to have revolutionised thinking about management behaviour, and has also been highly influential in health and social care.



Recall the case study of Maz’s development of her leadership skills over time. Do you think she was a situational leader? Why?

The position of Hersey et al. (2008) is that leadership style is best assessed and used situationally. In other words, there is no single ‘best style’ for a leader. Rather, it depends on the environment in which it is being applied. Situational leadership theory reinforces the idea that leaders are responsible for fostering growth and development, both in themselves and in other people. This is exemplified in the following case of a social care manager.

Case study 3.3: A situational leader

It’s very hard for me, an email will come in or a phone call outlining something that’s gone wrong, my immediate reaction is to immerse myself into it, to go and sort it out, a really action man approach.

[It’s] not my job, [it’s] undermining for everybody in the chain who works for me and not the right thing to do so what I always do now is allow myself a period of reflection ... I talk

to the senior people in the line and agree with them what they're going to do, whereas two years ago I imagine I would have trodden all over them and sorted it out.

(Social care leader, quoted in NSASC, 2011, p. 71)

As this case shows, leaders need to have sufficient self-awareness to be able to decide when it is appropriate to 'back off' and enable others to 'step up' and take the lead. Situational leadership theory focuses on follower maturity – the ability and willingness of people to take responsibility for directing their own behaviour, in terms of both job maturity and psychological maturity. It is important to remember, therefore, that to have effective leadership there needs to be effective followership.

Followership is described as the relationship between leaders and followers, where each has different but equal roles, both geared towards a common purpose. Goleman et al. (2002) describe followers as the mirror image of leaders; however, there is an imbalance in the attention paid to followers and followership. Leadership theories often overlook the role of followers in advancing effective leadership. People with a high level of follower maturity have the knowledge, ability and experience to perform their job tasks without direction from others. They are self-motivated and willing to perform a task without the need for much encouragement from other people. Recognition by leaders of the role that followers play in working towards a common goal will enhance the likelihood of success.

Given the complexity of leadership styles and thinking, Handy (1993) suggests that it is quite understandable if managers give up trying to identify a best fit and merely impose their habitual style on the task and their followers. However, he also suggests that an individual leader's ability to adapt is very largely governed by his or her relationship with the group, and that an effective leader needs to invest considerable energy in building the required relationship from the outset. Often this is about distributing leadership throughout a team or an organisation.

What is your dominant leadership style? How easily do you adapt to different situations?

Distributed leadership

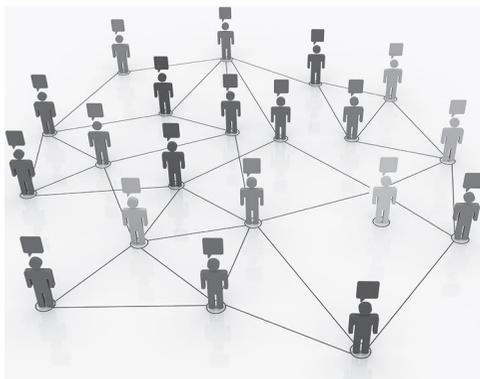


Figure 3.8 Leadership is not always about one person

An alternative way of thinking about leadership is to create an environment in which leadership is provided by many members of an organisation, rather than being vested in a few powerful individuals (Figure 3.8). The thinking behind such 'distributed' (or shared) leadership may be increasingly applicable in health and social care services which are becoming ever more complex to manage and lead. The delivery of care is shifting from teams working within hierarchical organisational structures towards multidisciplinary teams operating across practice boundaries. It is not surprising, therefore, that distributed leadership is now being promoted across both health and social care settings (see, for example, The King's Fund, 2011; National Skills Academy, 2011).

Could distributed leadership just be a clever way of getting people to do more for less?

In distributed leadership, the focus is on collegiality, joint action, sharing roles, opening up boundaries, fluidity, and harnessing all available expertise. In short, it involves letting go of the overall control associated with hierarchical management. Individuals at all organisational levels are encouraged to think of themselves as leaders, so that their individual skills and abilities are fully used and their talents are unlocked. What becomes important then is the collective leadership provided by both formal and informal leaders across an organisation (Day et al., 2004).

The complex processes involved in this form of leadership have implications for how organisations might be designed and managed. Both team and organisational performance are likely to suffer if different leaders cannot agree on what or how things should be done. Large organisations such as Social Services and the NHS are often

criticised for their lack of communication between different sections or departments; considering how distributed leadership might be put in place could help here.

Trevor and Kilduff (2012, p. 150) suggest the focus should be on enabling coalitions, and that 'coexistence and collaboration within and across networks' are the charismatic qualities required in distributed leadership. They argue that, once more, charisma is integral to the development of leadership. However, rather than seeing charisma as a quality of the lucky few (the 'great men'), they suggest that charisma can be developed by leaders engaging closely with their teams, gaining advice from people, becoming experts, treating people with consideration, being available to give advice, and integrating with people at all levels. The implication is that leaders who focus on developing their emotional intelligence are in a good position to facilitate distributed leadership across their unit and, ultimately, across their organisation (see Chapter 2 for more on emotional intelligence).

What is the weakness in distributed leadership?



Box 3.5 describes an initiative by the NHS Leadership Academy (2011), focusing on the value of promoting distributed leadership.

Box 3.5: The Leadership Framework (NHS Leadership Academy, 2011)

With a greater demand for efficiency in public services, there is a real need to ensure that leaders are developed in a well-considered way that will equip them with the skills and ability to lead effectively. The NHS Leadership Academy framework (2011) provides a single overarching structure for the leadership development of staff across all disciplines, roles and functions, which can apply to staff at any stage of their career.

The framework was developed from the premise that acts of leadership can come from anyone in the organisation. It emphasises the responsibility of all staff in demonstrating appropriate behaviours, in seeking to contribute to the leadership process, and to develop and empower the leadership capacity of colleagues.

At the heart of the framework is the core vision of delivering a good quality service to users, carers and members of the public (Figure 3.9).



Figure 3.9 NHS Leadership Academy framework (2011)

The Leadership Framework outlines seven domains which are integral to improving quality and safety in any health and social care setting. There are five core domains (in the centre of Figure 3.9) in which all staff should be competent, and a further two domains (on the outer edges) which focus more on the role and contribution of those in senior positions or roles.



Earlier, this chapter explored Adair’s action-centred leadership model, focusing on the task, the team and the individual. What similarities are there between Adair’s model and the NHS Leadership Framework?

3.6 Conclusion

Enacting leadership with vision is about motivating and influencing people, and shaping and achieving outcomes. There is an array of leadership theories which can help to understand that process. However, theories are not right or wrong; their value lies in the extent to which they may be useful or effectively applied to a given situation. One thing this chapter cannot do is to tell you how to lead, as that depends on the situation you are in as a leader, as well as the goals and vision you are working towards in your organisation. But what is clear from this overview of key influential ideas about leadership is that, by working together across an organisation, leaders with a clear vision, who are aware of the needs of their team and the individuals within it, have the power to achieve greater efficiencies than working alone.

Once again, this reinforces the importance of the four basic building blocks of caring leadership and management. As a result of personal, team, goal and contextual awareness, leaders are more likely to meet their vision of providing quality care to service users and their families and carers.

This chapter has demonstrated that a leader in health and social care should be one who knows the way, goes the way and shows the way, as suggested in the opening quotation (Figure 3.1).

Key points

- Leadership as a set of processes occurs both among and between individuals, groups and organisations.
- Vision, when clearly articulated, is a core component of leadership that motivates people to higher levels of effort and performance.
- While it was once widely assumed that ‘natural leaders’ were born, research on leadership in action shows that leadership skills can be developed.
- Leadership is about handling constant change and adaptable leaders need to change their style to suit their situation.
- Distributed leadership has the potential to enhance the effectiveness of large, complex organisations.

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