What Makes Leadership Work in Health and Social Care?

A Critical Review of Leadership Theory, Motivation, and Team Performance

By: Gursharnpreet Kaur Hanns

Abstract

Background: Health and social care systems operate amid workforce shortages, financial constraint, demographic ageing, and rising demand, and the quality of leadership within them is now understood to shape patient safety, staff retention, and organisational culture directly.

Approach: This report critically reviews the leadership theories most widely applied in the sector (transformational, transactional, servant, and authentic), the major motivational frameworks (Maslow, Herzberg, Vroom, and Taylor), and the principal models of team development and leadership (Tuckman, Belbin, and Adair), synthesising peer-reviewed evidence, regulatory and workforce reports, and the author's own leadership practice in educational and clinical support roles.

Findings: No single leadership theory is sufficient in isolation. Transformational and authentic leadership are consistently associated with psychological safety, job satisfaction, and patient safety outcomes, while transactional mechanisms remain necessary for governance and regulatory compliance. Motivation research indicates that hygiene factors prevent dissatisfaction but that intrinsic motivators , recognition, autonomy, and professional growth , sustain engagement, and that turnover in high-income health systems is driven above all by workload, burnout, and inadequate support. Performance management contributes most when developmental rather than punitive, and effective teams depend on shared goals, role clarity, and open communication under adaptive management.

Conclusion: Sustainable health and social care performance depends on blended, compassionate, and accountable leadership that aligns organisational governance with workforce wellbeing, supported by continuous improvement, benchmarking, and inclusive leadership development.

Keywords: *healthcare leadership, transformational leadership, motivation, psychological safety, team performance, patient safety*

1. Introduction

Leadership within health and social care has evolved considerably in response to workforce instability, regulatory complexity, technological advancement, and rising service demand. Health systems now operate in environments characterised by financial constraint, demographic ageing, digital transformation, and heightened public scrutiny, and the rapid expansion of data-driven decision-making, electronic health records, and remote care delivery has required leaders to develop technological literacy alongside traditional managerial competence. At the same time, transparency expectations from regulators and service users have intensified accountability pressures across the sector (Care Quality Commission [CQC], 2024; NHS England, 2023; NHS Leadership Academy, 2013). The COVID-19 pandemic further reshaped perceptions of healthcare leadership by demonstrating the necessity of rapid decision-making, adaptive coordination, and emotional resilience: leaders were required to manage uncertainty, redeploy staff, address ethical dilemmas, and sustain morale under extreme pressure (Buchan et al., 2022; West et al., 2014).

Leadership is therefore no longer viewed as a purely administrative function but as a strategic mechanism that directly shapes organisational culture, patient outcomes, and workforce sustainability. Empirical evidence links nurse managers' transformational leadership behaviours to higher job satisfaction and fewer adverse patient outcomes (Boamah et al., 2018), while collective and compassionate leadership approaches are associated with stronger safety cultures and staff engagement (West et al., 2014). By contrast, rigid hierarchical structures have been associated with lower engagement and reduced innovation, particularly within multidisciplinary teams (NHS Leadership Academy, 2013; Singh et al., 2024).

Clinical governance frameworks increasingly require leaders to integrate human-centred leadership with measurable performance accountability, balancing compassion with compliance while navigating policy reform, financial restructuring, and workforce shortages (NHS England, 2023; Walburg et al., 2006). The shift towards integrated care systems additionally demands collaboration across organisational boundaries, strengthening partnerships between hospitals, community services, and social care providers (NHS England, 2023; West et al., 2014).

In my view, effective leadership in health and social care must transcend traditional hierarchical authority and embed ethical accountability, transparency, and workforce compassion as core organisational values. This interpretation aligns with contemporary evidence that compassionate and inclusive leadership strengthens psychological safety, reduces burnout, and improves patient experience (Alilyyani et al., 2018; Buchan et al., 2022; West et al., 2014). This report critically

analyses the major leadership theories and their contribution to trust and accountability, evaluates the contemporary challenges facing sector leaders, examines motivational theory and performance management, and assesses the features of effective team performance, drawing throughout on current evidence and on my own leadership practice.

2. Leadership Theories: A Critical Analysis

Transformational leadership, first articulated in its modern form by Bass (1985), remains one of the most widely examined theories in contemporary healthcare research. It is characterised by the leader's ability to inspire followers through a shared vision, intellectual stimulation, individualised consideration, and idealised influence. Within health and social care, transformational leaders encourage innovation, support reflective practice, and motivate staff to move beyond minimum role expectations in pursuit of collective improvement. Empirical evidence consistently demonstrates that transformational leadership positively influences patient safety culture, employee engagement, and job satisfaction, particularly within nursing and multidisciplinary clinical environments (Boamah et al., 2018; Singh et al., 2024), and reviews of the wider organisational literature link it to improved psychological well-being among staff (Arnold, 2017). Transformational leadership also strengthens team cohesion and psychological safety, enabling staff to speak openly about clinical concerns and contribute to service improvement (West et al., 2014).

Critical evaluation nevertheless reveals limits. Healthcare organisations operate within complex governance structures that require measurable performance indicators, risk management protocols, and clearly defined accountability mechanisms; transformational inspiration without operational structure may create ambiguity about responsibility and performance expectations (NHS England, 2023; Walburg et al., 2006). Some commentators further argue that an excessive emphasis on vision-driven leadership can neglect the resource limitations and financial realities that are central to healthcare management (Singh et al., 2024).

Transactional leadership addresses this limitation by emphasising measurable objectives, structured supervision, and performance monitoring, operating through clearly defined expectations, reward systems, and corrective mechanisms. In settings where patient safety protocols must be strictly followed, transactional mechanisms provide the governance and accountability structures that protect patients and professionals alike (NHS England, 2023; Walburg et al., 2006), and the associated clarity can enhance role understanding and reduce operational uncertainty in high-risk environments such as emergency departments and critical care units (Singh et al., 2024). Over-

reliance on transactional approaches, however, may erode intrinsic motivation and create environments perceived as bureaucratic rather than empowering. Healthcare professionals typically enter the field with strong intrinsic motivation linked to patient care values and professional identity; when leadership focuses predominantly on compliance and performance metrics, staff may experience reduced autonomy and lower engagement, and accountability systems perceived as punitive can undermine psychological safety (Boamah et al., 2018; West et al., 2014).

Servant leadership has gained increasing relevance in health and social care because of its alignment with care ethics and patient-centred values. Originating with Greenleaf (1977), it prioritises the growth, wellbeing, and empowerment of employees on the premise that workforce satisfaction directly influences patient experience and safety outcomes. A systematic review of 285 studies confirms that servant leadership, characterised by listening, empathy, and shared decision-making, fosters trust, collaborative practice, and positive follower outcomes (Eva et al., 2019), and the supportive workplace cultures it promotes contribute to reduced burnout and improved staff retention (Buchan et al., 2022).

Authentic leadership further strengthens ethical legitimacy within healthcare organisations. Grounded in self-awareness, transparency, and consistency between personal values and professional actions, it encourages open communication and enhances trust among staff and service users; a systematic review of healthcare settings identifies authentic leadership as an antecedent of trust, work engagement, and healthier work environments (Alilyyani et al., 2018). In regulated systems where public trust is critical, authentic leadership reinforces accountability and moral responsibility while supporting psychological safety (West et al., 2014).

From a critical perspective, no single leadership theory adequately addresses the multidimensional pressures facing modern health systems: transformational leadership provides inspiration, transactional leadership ensures compliance, servant leadership reinforces compassion, and authentic leadership sustains trust (Singh et al., 2024) (Table 1). In my opinion, a hybrid framework that integrates transformational inspiration, transactional governance, and authentic ethical grounding provides the greatest strategic stability in complex healthcare environments, allowing leaders to inspire innovation while maintaining compliance with clinical standards and balancing compassion with accountability. Effective leadership in health and social care is ultimately not about selecting a single theoretical model but about applying the appropriate elements of each according to context, risk level, and organisational need (Singh et al., 2024; West et al., 2014).

Table 1

Comparative analysis of four leadership theories in health and social care

Dimension	Transformational	Transactional	Servant	Authentic
Core focus	Inspiring change through a shared vision	Structure, rewards, and corrective supervision	Growth and wellbeing of staff	Self-awareness and ethical consistency
Key strengths	Engagement, innovation, safety culture	Compliance, clarity, accountability	Trust, collaboration, retention	Trust, moral legitimacy, openness
Main limitations	May lack operational structure	Can erode intrinsic motivation	Slower decisions in crises	Depends heavily on leader integrity
Best-fit context	Change and improvement programmes	High-risk, regulated routines	Person-centred and community care	Regulated, trust-critical settings

Note. Synthesised from Bass (1985), Greenleaf (1977), Alilyyani et al. (2018), Eva et al. (2019), and Singh et al. (2024). The strongest contemporary frameworks blend the strengths of all four rather than adopting any one in isolation.

3. Leadership, Trust, and Accountability

Trust within multidisciplinary healthcare teams is essential for safe, coordinated, and patient-centred care. Modern healthcare relies on collaboration among nurses, physicians, allied health professionals, managers, and support staff, and effective coordination cannot occur without mutual confidence in professional competence and ethical conduct. Psychological safety enables staff to report errors, near misses, and concerns without fear of punishment, which strengthens learning cultures and reduces clinical risk (West et al., 2014). Environments characterised by openness and inclusivity are associated with improved safety reporting and stronger engagement (Boamah et al., 2018; NHS Leadership Academy, 2013), and transformational and authentic leadership styles are strongly associated with fostering such environments through open communication, consistent moral behaviour, and visible commitment to shared values (Alilyyani et al., 2018; Boamah et al., 2018).

Transactional clarity reinforces accountability by establishing defined roles, structured supervision, and measurable performance indicators. In highly regulated environments such as acute hospitals and community care services, this clarity is necessary to ensure compliance with professional standards, clinical governance frameworks, and patient safety protocols (NHS England, 2023; Walburg et al., 2006). Clear delegation, transparent reporting lines, and consistent monitoring provide stability within complex organisational systems and reduce ambiguity in high-pressure

situations. Critical literature emphasises, however, that accountability mechanisms must avoid becoming punitive or fear-based, because cultures of blame discourage reporting, suppress innovation, and weaken professional confidence (Acas, 2023; West et al., 2014).

In my view, trust and accountability are interdependent constructs rather than opposing forces. Accountability without trust can create anxiety and defensive practice, while trust without accountability may compromise consistency and standards. Organisations that prioritise surveillance over psychological safety may inadvertently increase error by suppressing open communication and limiting reflective practice, whereas balanced leadership that integrates transparency with developmental accountability is more likely to sustain high-quality care and long-term organisational resilience (Alilyyani et al., 2018; West et al., 2014). Leaders who demonstrate fairness, consistency, and empathy reinforce the principle that accountability exists to improve systems rather than assign blame, which ultimately strengthens both professional integrity and patient outcomes (NHS Leadership Academy, 2013).

4. Contemporary Leadership Challenges

The global health workforce shortage represents one of the most significant structural challenges confronting healthcare leaders in the present decade. Before the COVID-19 pandemic the world already faced a shortfall of almost six million nurses, a deficit the pandemic has deepened, with up to 13 million additional nurses projected to be required over the coming decade (Buchan et al., 2022; World Health Organization [WHO], 2020). Demographic change has increased demand for long-term condition management, palliative care, and community-based services, while the supply of qualified professionals has struggled to keep pace, and international migration patterns have created stark disparities in staffing across regions and sectors (Buchan et al., 2022; WHO, 2020). In England, the first comprehensive workforce plan for the NHS acknowledges the scale of the problem and commits to a major expansion of training, retention, and reform (NHS England, 2023), while the Care Quality Commission (2024) reports that difficulties with recruitment, retention, and understaffing are already affecting people's care. Financial constraints compound these pressures by limiting recruitment capacity and restricting investment in workforce development, digital transformation, and infrastructure (CQC, 2024; NHS England, 2023).

Burnout has been empirically linked to reduced patient safety, lower engagement, diminished empathy, and decreased attentiveness to safety protocols, and prolonged exposure to high workload, moral distress, and staffing shortages erodes professional motivation and increases absenteeism and

turnover (Buchan et al., 2022; West et al., 2014). An umbrella review of turnover across the healthcare and welfare sectors of high-income countries identifies workload, burnout, low staffing, and inadequate managerial support among the most consistent drivers of staff intention to leave (Wynendaele et al., 2025). Leaders must therefore balance operational efficiency with workforce wellbeing, recognising that short-term productivity gains achieved through excessive workload expectations generate long-term organisational risk; investment in supportive supervision, mental health resources, and flexible workforce planning is increasingly a strategic necessity rather than an optional benefit (Buchan et al., 2022; NHS England, 2023).

Ethical complexity further complicates leadership responsibilities. Decisions about resource allocation, service prioritisation, waiting list management, and workforce restructuring require moral sensitivity, transparency, and fairness, and they are scrutinised by regulators, service users, and the wider public (CQC, 2024; NHS England, 2023). In my opinion, strategic workforce planning and compassionate leadership are essential survival strategies rather than optional initiatives: systems operating under chronic strain cannot sustain safe and effective performance without prioritising staff wellbeing, transparent governance, and long-term workforce investment. Sustainable reform requires leaders who recognise that workforce stability, ethical integrity, and patient safety are interconnected rather than competing priorities (Buchan et al., 2022; West et al., 2014; WHO, 2020).

5. Motivation Theory and Organisational Performance

Motivation theories provide valuable insight into workforce retention, engagement, and performance quality within health and social care. Maslow's (1943) hierarchy of needs proposes that physiological and safety needs must be satisfied before individuals can pursue higher-order needs such as esteem and self-actualisation. Within healthcare, job security, safe staffing levels, manageable workloads, and supportive relationships underpin higher-order performance, and where foundational needs such as rest, nourishment, and physical safety are compromised , as they often are during long shifts and busy clinical periods , performance and decision-making capacity decline (Buchan et al., 2022; WHO, 2020). Healthcare organisations therefore increasingly recognise the importance of safe staffing ratios, structured breaks, and supportive rest facilities. Some systems go further in reducing external stressors: Hamad Medical Corporation in Qatar, for example, provides employment packages including housing assistance and educational support for employees' children, an approach consistent with Maslow's principle that reducing insecurity outside the workplace strengthens engagement within it.

Herzberg's two-factor theory refines this understanding by distinguishing hygiene factors , pay, organisational policy, and working conditions , from intrinsic motivators such as recognition, achievement, and responsibility (Herzberg et al., 1959). Hygiene factors prevent dissatisfaction but do not in themselves create long-term commitment; in healthcare, recognition of clinical expertise, opportunities for leadership development, and meaningful involvement in decision-making contribute more strongly to job satisfaction and professional fulfilment (Boamah et al., 2018; West et al., 2014). Taylor's (1911) scientific management, although historically associated with productivity measurement and financial incentives, also remains partly relevant: measurable targets, waiting-time standards, and performance monitoring provide useful structure (NHS England, 2023; Walburg et al., 2006). Over-application of purely output-driven systems, however, can reduce intrinsic motivation if professionals feel reduced to performance metrics, and perceived inequity in rewards or bonuses can corrode engagement and, in a care context, carry genuine risks for patients. Contemporary leadership must therefore balance structured performance incentives with intrinsic and relational motivators.

Vroom's (1964) expectancy theory suggests that employees increase effort when they perceive that performance will lead to valued and attainable outcomes, highlighting the importance of transparent appraisal systems, fair promotion pathways, and visible recognition. In healthcare, valued outcomes often extend beyond financial reward to include professional autonomy, skill development, and contribution to patient wellbeing; when staff believe their effort improves patient outcomes and is acknowledged by leadership, motivation and discretionary effort increase (Boamah et al., 2018; West et al., 2014). This reflects a broader finding that many healthcare professionals are intrinsically motivated by purpose, ethical commitment, and patient care values (Buchan et al., 2022). Consistent with this, evidence on turnover shows that staff leave predominantly for reasons of workload, burnout, and poor support rather than pay alone (Wynendaele et al., 2025), which cautions against purely transactional retention strategies. In my view, motivational theory must be operationalised through practical leadership behaviours: leaders who recognise contribution, protect rest, create supportive environments, and provide growth opportunities establish cultures capable of sustaining high performance under sustained pressure.

6. Factors Influencing Motivation and Performance

Organisational culture shapes behaviour patterns, professional norms, and team dynamics within health and social care. Classic work on organisational culture, such as Ouchi's (1981) Theory Z,

emphasises that cultures built on trust, mutual commitment, and long-term investment in people outperform those built on control. Positive cultures characterised by collaboration, shared purpose, and mutual respect enhance engagement and reduce interpersonal conflict, and healthcare organisations with strong cultures of respect and learning experience improved patient outcomes and lower staff turnover (West et al., 2014; Wynendaele et al., 2025). When leaders actively promote inclusivity and fairness, teams are more likely to demonstrate cohesion and collective responsibility (NHS Leadership Academy, 2013).

Empowerment is a central component of constructive organisational culture. When healthcare professionals are trusted to exercise clinical judgement and participate in decision-making, they develop a stronger sense of ownership and accountability, and they are more willing to initiate service improvements, share ideas, and challenge unsafe practices (Boamah et al., 2018; NHS Leadership Academy, 2013). Flexible working arrangements and wellbeing initiatives also play a significant role: policies that support flexible scheduling, structured rest breaks, and access to mental health resources contribute to reduced burnout and improved morale, and organisations investing in staff welfare demonstrate improved retention (Buchan et al., 2022; NHS England, 2023).

Communication transparency further strengthens psychological safety and trust. Open dialogue about performance, errors, and organisational challenges enables collective problem-solving and continuous improvement, and reduces uncertainty about leadership decisions (West et al., 2014). In my opinion, communication transparency and psychological safety are stronger predictors of sustainable performance than financial incentives, because healthcare delivery depends fundamentally on trust, ethical clarity, and collaborative practice: financial rewards may influence short-term motivation, but long-term excellence is sustained through shared purpose and mutual respect (Boamah et al., 2018; West et al., 2014).

7. Performance Management and Organisational Success

Performance management aligns organisational objectives with workforce behaviour by translating strategic priorities into measurable standards of practice. In health and social care, where patient safety and service quality are paramount, structured performance frameworks provide clarity about expectations and accountability. Key performance indicators such as patient satisfaction scores, waiting times, infection control rates, and clinical safety metrics enable systematic monitoring of quality and efficiency, allowing leaders to identify trends, detect concerns, and implement corrective strategies in a timely manner (NHS England, 2023; Walburg et al., 2006). Applied effectively, such

systems enhance transparency and strengthen confidence among service users and regulatory bodies (CQC, 2024).

Structured appraisal systems support professional development by creating opportunities for reflection, feedback, and goal setting. Regular reviews enable managers to identify training needs, recognise achievement, and align individual objectives with organisational priorities, while giving staff space to raise concerns and discuss career aspirations , processes that strengthen engagement and retention when handled developmentally (Acas, 2023; West et al., 2014). Benchmarking facilitates comparative learning by enabling organisations to measure performance against national standards and replicate best practice, although it must be contextualised, since variations in patient demographics, resource allocation, and service configuration influence outcomes (NHS England, 2023; Walburg et al., 2006).

In my opinion, performance management should prioritise continuous improvement and learning rather than punitive enforcement. Accountability is essential in healthcare because of its direct impact on patient safety, but an excessive focus on fault-finding undermines morale and reduces openness. Healthcare professionals respond more positively to developmental feedback systems that recognise effort, encourage growth, and promote reflective practice (Acas, 2023; West et al., 2014). Performance management that integrates supportive supervision with measurable standards creates balanced accountability, sustaining both workforce wellbeing and organisational excellence.

8. Personal Practice and Contribution to Positive Organisational Culture

In my own leadership practice I prioritise transparency, fairness, and shared objectives. During my role as a Lead Supervisor within the Health Professions Awareness Programme, I was responsible for guiding and educating students while ensuring that organisational policies and behavioural standards were upheld. Despite being relatively young in comparison to some participants, I recognised that leadership credibility is established through consistency, preparation, and respectful communication rather than age or authority alone. Open communication reduced misunderstandings and strengthened trust within the student groups, and encouraging feedback and reflective discussion allowed students to express concerns freely, which promoted accountability and created a learning-focused environment (NHS Leadership Academy, 2013; West et al., 2014).

The programme required students to sit through lectures that sometimes exceeded four hours, often during their holiday period. Maintaining engagement under these circumstances required adaptive

leadership rather than rigid enforcement. While rules on attendance, punctuality, and respectful behaviour had to be upheld, I applied them in a balanced and proportionate manner, incorporating interactive discussions, practical examples, and short engagement activities to sustain concentration and enthusiasm. Inclusive and participative approaches of this kind are associated with stronger engagement and lower resistance (NHS Leadership Academy, 2013; West et al., 2014). Supporting wellbeing was equally central: I ensured students received structured breaks and opportunities to refresh themselves, adjusting session pacing when fatigue threatened learning quality , an approach consistent with evidence that supportive supervision and flexible planning strengthen morale and resilience even within structured environments (Buchan et al., 2022).

In my opinion, modelling integrity and respect influences organisational culture more profoundly than policy documentation alone, because behavioural consistency shapes team norms and expectations. Even within a student setting, leadership behaviour set the tone for participation and discipline: by enforcing rules through explanation and rationale rather than authority alone, I maintained order while sustaining engagement. This balanced approach reflects contemporary leadership research, which emphasises transparency, empathy, and psychological safety as the foundations of effective practice (Alilyyani et al., 2018; West et al., 2014).

9. Effective Team Characteristics and Leadership Models

Effective healthcare teams demonstrate shared goals, clearly defined roles, and collaborative communication across professional boundaries. Modern health and social care delivery relies on multidisciplinary teams of doctors, nurses, nursing assistants, allied health professionals, pharmacists, and administrative staff; each member contributes specialised knowledge, yet safe and effective care depends on coordinated interaction rather than isolated expertise. Tuckman's (1965) developmental sequence , forming, storming, norming, performing , provides a structure for understanding team progression and allows leaders to recognise conflict as a natural phase rather than a failure of competence. Belbin's (2010) team-role theory emphasises complementary roles that improve task allocation and reduce interpersonal conflict: within multidisciplinary teams, some individuals naturally adopt coordinating roles while others contribute analytical, creative, or supportive strengths, and recognising these differences reduces role ambiguity and tension. Adair's (1973) action-centred leadership model integrates task achievement, team maintenance, and individual development, highlighting that effective leaders must address performance outcomes,

relational dynamics, and personal growth simultaneously , an integration of particular importance in healthcare, where patient safety relies on both technical competence and respectful collaboration.

During my experience as a nursing assistant, I observed at first hand how multidisciplinary collaboration influences patient care, and what it feels like to work in a supporting clinical role alongside senior nurses and physicians. Although hierarchical structures exist within healthcare to ensure accountability and clinical governance, rigid hierarchy can unintentionally foster disrespect or reduce confidence among junior staff; where power defines perceived status, communication barriers can emerge that affect teamwork and patient safety. Inclusive leadership reduces hierarchical tension and encourages open dialogue across professional levels (NHS Leadership Academy, 2013; West et al., 2014).

In my opinion, structured team development models are particularly valuable in multidisciplinary contexts because they promote mutual respect and clarify responsibilities regardless of hierarchy. When roles are clearly defined and communication channels remain open, junior staff feel empowered to raise concerns without fear of dismissal, which strengthens psychological safety and reduces clinical miscommunication (Belbin, 2010; West et al., 2014). Hierarchy is necessary for accountability, but it should never translate into inequality of respect: effective leadership ensures that authority is exercised with fairness and professionalism, and that every role within the team is recognised as contributing meaningfully to patient wellbeing.

10. Overcoming Challenges to Effective Team Performance

Conflict, workload imbalance, and stress can significantly undermine team effectiveness in health and social care. High-pressure environments, shift patterns, and emotionally demanding clinical situations create tension between team members and reduce collaborative efficiency, and unresolved conflict can lead to communication breakdowns that affect patient safety. The pandemic intensified these pressures by increasing patient volumes, disrupting staffing patterns, and forcing rapid adaptation to redeployment and infection control measures (Buchan et al., 2022). Mediation processes and structured supervision became even more essential in this period, providing safe spaces for dialogue and emotional processing (Acas, 2023).

Continuous professional development enhances competence, confidence, and role clarity in complex and evolving clinical environments. During the pandemic, access to rapid training programmes, simulation exercises, and reflective debriefing strengthened team capability and reduced anxiety

linked to uncertainty, while coaching and mentoring helped maintain morale through periods of crisis (Buchan et al., 2022; NHS England, 2023). Such interventions contribute not only to competence but also to collective resilience and trust within multidisciplinary teams (West et al., 2014).

In my opinion, proactive leadership that anticipates stressors and invests in resilience strategies is more effective than reactive conflict management. Leaders who recognise early signs of fatigue, moral distress, and workload imbalance are better positioned to implement supportive measures before performance declines, and the pandemic demonstrated that healthcare teams can achieve extraordinary collaboration under pressure when supported by transparent communication and compassionate leadership (Buchan et al., 2022; West et al., 2014). Sustainable team effectiveness therefore depends on leaders who embed wellbeing, adaptability, and continuous learning into everyday practice rather than addressing challenges only once they escalate.

11. Management Styles and Team Outcomes

Participative management enhances engagement, shared accountability, and collective ownership of organisational goals. When leaders involve staff in decision-making, they strengthen commitment, encourage collaborative problem-solving, and support professional autonomy , effects that are well documented in healthcare settings where cooperation is essential for safe patient outcomes (Boamah et al., 2018; West et al., 2014). Inclusive styles are associated with higher morale, improved retention, and stronger safety cultures (NHS Leadership Academy, 2013; Wynendaele et al., 2025).

Authoritative approaches nevertheless remain necessary in emergency clinical scenarios where rapid decision-making is critical. In resuscitation events, trauma care, or urgent surgical intervention, hesitation or prolonged consultation can compromise patient safety, and clear direction ensures coordinated action in time-sensitive environments (NHS Leadership Academy, 2013; Singh et al., 2024). Excessively rigid management applied beyond crisis contexts, however, reduces morale and suppresses innovation: overly strict supervision, limited autonomy, and inflexible policy enforcement weaken engagement and discourage professional initiative, and leadership perceived as authoritarian without explanation or empathy erodes psychological safety (Boamah et al., 2018; West et al., 2014).

In my opinion, adaptive management , combining participative planning with authoritative crisis leadership , offers the most sustainable model for healthcare organisations facing unpredictable demands. Leaders must be capable of shifting between inclusive consultation during strategic planning and decisive authority during emergencies, a situational flexibility that reflects the

complexity of healthcare environments where routine operations coexist with sudden clinical escalation (NHS Leadership Academy, 2013; Singh et al., 2024). By balancing empowerment with clarity, adaptive leadership supports both workforce engagement and patient safety.

12. Recommendations

First, healthcare organisations should implement blended leadership development programmes that integrate transformational inspiration with transactional governance. Transformational elements cultivate vision, engagement, and collective purpose, while transactional mechanisms ensure clarity, compliance, and measurable accountability; training should therefore include both relational competencies, such as emotional intelligence and communication, and structural competencies, such as risk management, performance monitoring, and regulatory understanding (Boamah et al., 2018; Singh et al., 2024; Walburg et al., 2006).

Second, investment in workforce wellbeing initiatives and structured professional development must be prioritised to address retention challenges. High turnover and workforce shortages continue to threaten system sustainability, particularly in nursing (NHS England, 2023; Wynendaele et al., 2025). Comprehensive wellbeing strategies should include mental health support, manageable workloads, and structured rest, alongside clear career progression pathways and continuous professional education (Buchan et al., 2022; West et al., 2014).

Third, performance management frameworks should emphasise benchmarking, continuous learning, and transparent feedback rather than compliance targets alone. Benchmarking against national and international standards enables comparative learning, while transparent appraisal encourages open dialogue about strengths and development areas, reinforcing trust between leaders and staff (Acas, 2023; Walburg et al., 2006).

Finally, leadership reform should encourage inclusive decision-making and multidisciplinary collaboration. Empowering frontline staff to contribute to service improvement enhances ownership and innovation, and shared governance structures that recognise professional voices at every level strengthen psychological safety and reinforce the principle that high-quality care is a collective responsibility (NHS Leadership Academy, 2013; West et al., 2014). In my opinion, sustainable reform must embed evidence-based strategy within organisational culture and everyday practice, combining strategic governance with empathy, transparency, and continuous learning to secure long-term patient safety and organisational resilience.

13. Conclusion

What makes leadership work in health and social care? The evidence reviewed here suggests that it is not any single theory or style but the disciplined integration of several. Transformational leadership supplies vision and engagement, transactional leadership supplies structure and accountability, servant leadership supplies compassion, and authentic leadership supplies trust (Bass, 1985; Eva et al., 2019; Singh et al., 2024). Motivation theory reinforces the same lesson from the other direction: staff are sustained less by pay and policy than by safety, recognition, autonomy, and growth (Herzberg et al., 1959; Maslow, 1943; Vroom, 1964), and they leave when workload and burnout go unaddressed (Buchan et al., 2022; Wynendaele et al., 2025). Effective teams, in turn, depend on shared goals, complementary roles, and leadership that adapts its style to the situation at hand (Adair, 1973; Belbin, 2010; Tuckman, 1965).

My own practice as a Lead Supervisor and nursing assistant has shown me that these principles operate at every level of the system, not only in the boardroom: credibility is built through consistency, engagement through inclusion, and safety through the psychological confidence of every team member to speak. Sustainable health and social care performance ultimately depends on adaptive leadership, ethical clarity, and structured team development. Stakeholders are encouraged to adopt integrated leadership strategies that align organisational governance with compassionate workforce practice, so that the system can remain stable, resilient, and genuinely patient-centred in the face of the pressures ahead (NHS England, 2023; West et al., 2014; WHO, 2020).

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