Understanding the relationship between followers and leaders

Susanne Kean and Elaine Haycock-Stuart argue that senior staff are not the only movers and shakers in a team. They suggest organisations need to look beyond research literature, which fails to acknowledge the influence of junior colleagues

Abstract

Contemporary healthcare policies tend to imply that successful leadership can be attributed to a single leader. Such an understanding of leadership ignores the significant contribution followers make to successful leadership and their influence on leaders. In reality, followers rarely simply follow leaders. Following is a complex process that depends on the context and involves followers making judgements about prospective leaders while deciding whether or not to follow them. This interdependence is ignored all too often or misunderstood by those who see leadership as something that can resolve the problems of the NHS. Using data from a study of leadership in community nursing in which the authors were involved, they argue that senior staff who ignore followers and their contribution to leadership do so at the peril of their organisations.

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THE TOPIC of leadership receives much attention from policy makers, governments, researchers and practitioners but, while policy papers frequently mention leadership, what exactly it is and how it can be developed remain elusive (Howieson and Thiagarajah 2011).

The prominence of leadership and leader development was particularly evident under the previous government, which instigated, for example, the development of the NHS leadership qualities framework. This defined the attributes leaders at all levels of the service were expected to have (NHS Institute 2005).

However, the framework did not apply to the medical profession, which has developed its own medical leadership competency framework (NHS Institute 2009). The Nursing and Midwifery Council (NMC) has included leadership as a specified domain in undergraduate nursing curricula from 2012 (NMC 2010).

The leadership qualities set out in both NHS frameworks, and the NHS Scotland leadership development strategy (Scottish Government 2009), consist of three clusters:

- Personal qualities and behaviours.
- Setting directions to achieve service priorities.
- Delivering the service to achieve goals.

'Personal qualities' are central to both frameworks (NHS Institute 2005, Scottish Government 2009). Each 'quality' is defined in the frameworks so, for example, under 'self-belief', it states that 'outstanding leaders maintain a positive "can-do" sense of confidence which enables them to be shapers rather than followers, in the face of opposition. The prime personal quality is built on success and learning in a broad range of varied situations over time' (NHS 2005 Institute).

Referring to 'outstanding leaders' indicates a continuing belief in the 'leader as saviour', whose purpose it is to solve organisations' problems (Collinson 2005). The leader-centricity of both leadership frameworks (NHS Institute 2005, Scottish Government 2009), and the sole focus on qualities and behaviours of leaders, further suggest that successful leadership can be attributed to individuals.

The evident failure of leadership frameworks, policies or development programmes to recognise the conceptual differences between leaders and leadership inherent in leadership frameworks is perplexing. The concept of 'leader' focuses on individuals, their behaviours and their personality traits, while 'leadership' is seen as a process that involves leading and following, leaders and followers (Hartley and Hinksman 2003, Grint 2005).

While the titles of frameworks, polices and development programmes often refer to leadership,

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the focus remains on individual leaders. This differs from their intention and needs to be questioned.

Describing leaders as 'shapers rather than followers' (NHS Institute 2005) oversimplifies the complexity of relationships between leaders and followers and misses the point of leadership development by focusing on leaders rather than on both groups.

They reduce the complexity of leadership to the personality and qualities of the leaders. It is important to recognise that successful leadership in organisations is the result of the actions of many (Peck and Dickinson 2009).

Followers and followership

Mainstream leadership development frameworks appear fixated on the idea that leaders are always in control and leading. At the same time, leadership development frameworks, and many contemporary leadership approaches, make the assumption that followers make up a homogeneous group that unquestioningly follows a leader.

Fineman (2003), who examined leadership from an emotional perspective, highlights the interdependence of leaders and followers, and argues that they are bound in a complex emotional web. Not only are leaders sometimes followers, and vice versa, but following and leading are also interdependent activities found in both groups.

Understanding the interdependency and reciprocity between leaders and followers is important because leadership or followership, and therefore leading or following, are processes that happen between people (Binney *et al* 2009) and affects all working relationships.

Study

'Following' emerged as a major theme of leadership in an analysis of a leadership study in community nursing in three health boards in Scotland undertaken by the authors with colleagues (Haycock-Stuart *et al* 2010, Kean *et al* 2011). The analysis concluded that the concept of following had four dimensions:

- Socially co-constructing leaders. Co-constructing is a term used to describe how people constantly redefine their environments through interacting with, and reacting to, others.
- Doing following.
- Standing by.
- Resisting following.

These dimensions illuminate the complex process by which followers influence and co-construct leadership and thereby influence an organisation's ability to achieve its goals.

The leadership study (Haycock-Stuart *et al* 2010, Kean *et al* 2011) used various qualitative methods; it involved 31 individual interviews and discussions in three focus groups, with an overall sample of 39. The study aimed to identify how leadership is perceived and experienced by community nurses, and to examine the interaction between recent policy and leadership development in community nursing in the UK.

Multi-site ethical and management approval from all research and development departments of the three health boards was granted. Nurses working in the community were invited to participate. The study sample represents community nurses and their leaders in three health boards and reflects a highly experienced and older workforce, which is in line with earlier findings (Buchan *et al* 2008).

Tables 1 and 2 show the breakdown of participants by professional role and their banding within the NHS knowledge and skills framework (Department of Health (DH) 2004).

The interview schedule was developed after a literature review and integrated with questions posed by the funding body, while the focus groups' topic guide was drawn up after the individual interviews. The interview and focus group sessions were audio recorded digitally and transcribed verbatim after participants gave written consent. Data were gathered between April and December 2009. Further details on methods and data analysis are given elsewhere (Haycock-Stuart *et al* 2010, Kean *et al* 2011).

Findings and discussion

It became evident in the interviews that the interplay between leading and following among followers significantly affected leadership processes.

Socially co-constructing leaders When asked what makes a good leader, participants listed several qualities, such as being listened to by their leader, being honest, being visible, being approachable, and having a vision. These qualities appeared to conform with a trait approach to leadership and to underline the approach taken in many leadership development frameworks.

However, when participants were asked how they recognised leaders, a more complex pattern emerged. They argued that recognition of a leader is not immediate, it takes time and one 'would have to be working with someone for a while before you would recognise… that your team was running well' (district nurse 3.4).

Participants described a process of stepping back and observing leaders, which led to judgements about them. The co-construction of leaders happened on an individual as well as group level, because nurses would come to conclusions based not only on their own observations of their leaders, but also draw on discussions of their views with peers. Nurses in leading positions were aware that they were being judged and commented that 'leadership is also about… having a vision and having a direction and you can't be a leader if you haven't got followers. So there is something about engagement and taking people with you' (lead nurse 1.2).

Data suggest that, across the sample, followers reflected on their leaders' ability to take people with them and carefully analysed their intentions, competencies and actions before deciding whether or not to follow. This suggests that the proposition evident in many leadership approaches, that followers just follow, is naïve. Equally, leaders knew that their engagement with followers and 'having a vision and direction' was crucial for successful leadership.

Doing following Based on their judgement of their leaders, nurses were clear that they would 'not follow a numpty' (district nurse 2.4) and that, for them to follow, a leader had to be 'somebody that I would look up to and want to follow' (district nurse 3.2). Analysis across data illustrates that followers' judgements about their leaders were made within specific contexts. This insight is important because it underlines followers' continuous judgement of their leaders' actions, which in turn influences the followers' behaviour towards leaders (Hollander 2009).

Leaders understood this. One lead nurse (3.1) pointed out: '…You need to manage the change but, to move it forward…you need to bring people with you…you can't lead if people don't follow… So people have to have trust in you… If you say, "follow me, have a leap of faith", but you have absolutely no ability to actually deliver… people are going to be a wee bit, "well, hold on"…'

'Following' therefore occurred when nurses had 'trust' and 'faith' in the leader.

Table 1 Participants' professional roles

Position	Number of participants
District or community nurse	14
Community staff nurse	12
Health visitor	5
School nurse	0
Nursery nurse	2
Healthcare assistant	2
Acute care manager for the community sector	1
Assistant nursing director	1
Director of nursing	2

Table 2 NHS knowledge and skills framework band distribution of participants

	Health board 1	Health board 2	Health board 3
Band 2	2	0	0
Band 4	2	0	0
Band 5	5	4	3
Band 6	6	0	3
Band 7	5	2	1
Band 8	2	1	1
Executive level	1	1	0

(Department of Health 2004)

However, another dimension of following was raised by a district nurse who argued that 'some people are comfortable in their area… and don't really want to have their boat rocked… They're not gonna be so keen to look at different ways of working' (district nurse 1.3). This emphasised that any suggested change was linked, and needed to correspond, to followers' values and belief systems.

Standing by Initially 'standing by' may appear to be at odds with what the concept of following. This is a passive form of following and was evident when, for example, one participant said: 'I am definitely… like a follower rather than a leader. I'll do any amount of work, but I just need somebody there doing that kind of organising to get me into it' (district nurse 1.4).

It is important to recognise that 'standing by' does not happen coincidentally but is an active decision by a follower. At first sight, such followers can seem appealing, but they present problems for organisations and leaders because they do not provide leaders and peers with what Grint (2005) describes as 'constructive dissent'. It is their disengagement that is problematic for leaders and organisations; these followers stand on the sidelines and need to be told what to do, when and how much to do it, while refraining from giving feedback.

These data also indicate the importance of leadership processes being negotiated actively between leaders and followers. Leaders need to be flexible and make use of the leadership 'toolbox' in relation to the follower they are working with. In real life, a good leader does this and we saw examples of it.

Resisting following Organisational hierarchies create power asymmetries between people such as leaders and followers. As argued above, followers make judgements about leaders and have their own self-interests; as a result, they may resist, refuse or sidetrack attempts at change by their leaders if, for example, they consider that the suggested changes are not in their interests.

That leaders do not hold all the power – and that this is a counter-intuitive belief (Bratton *et al* 2005) – became evident when leaders in middle management, in particular, had at first considered that 'being a sort of manager, I could tell folk, suggest to folk that they do things… But it doesn't happen. People just don't do things' (team leader 1.1).

In this case, the team leader had attempted to adjust teamworking practice in a way that community nurses had not expected. The change was supported by the lead nurse, but community staff waited for the team leader's time off to raise their concerns about the changes with the lead nurse, who subsequently reversed the decision. Perhaps, not surprisingly, the team leader reflected on her power in the hierarchy and concluded that she did 'not have any clout. The clout lies at the next level up' (team leader 1.1).

In contrast, a nursing director dealing with senior leaders who engaged in 'often very personal sabotaging behaviour' (nursing director 1.1) had the power and means to access outside support by bringing in facilitators who held sessions with staff and successfully addressed issues of obstructive behaviour and change.

While leadership approaches argue for the transcendence of leadership, that is, enabling anyone at any level of an organisation to lead, data from across the health boards suggest that leadership is based on people's positions in the NHS hierarchy. For example, if a nurse has a good and innovative idea, she would go to the nurse senior to her, but would not go beyond that level. The problem here is that whether the idea flies or is killed off right there depends on who is above. We saw examples of good ideas that never reached the nursing directors because they were blocked on the way up.

Analysis of our data shows that the position of leaders in the hierarchy shapes their responses to followers who resist, counteract or sidestep if suggested actions do not correspond with followers' values or belief systems.

In contrast to policies that see nurses as entrepreneurs shaping the system, in our experience, the success of good and innovative ideas for improving practice depended on people's position in the hierarchy. An idea put forward by a healthcare assistant that would, for example, involve a change of work focus and added effort on the part of registered nurse colleagues to make it happen may well be ignored. Several good ideas never reached nursing director level because of barriers between those who had the ideas and an interest in improving practice and those in positions of power.

Conclusion

Nurses and midwives are the largest group of healthcare professionals in the NHS and they are targeted routinely by policy makers to achieve politically desired changes to enable improvements in health care (Scottish Executive Health Department 2005, Scottish Government 2007, DH 2008).

Leadership is essential for improving care and achieving a 'better and fairer healthcare system' (DH 2008). However, thinking 'leadership' without thinking 'followership' is, as Kellerman (2008) puts it, 'not merely misleading, it is mistaken'. Furthermore,

leadership and followership are processes not people, a fact ignored or misunderstood all too often by those who see leadership as something that can heal all the ills that befall the NHS.

Followership, like leadership, is a complex process and is based on followers' co-construction of their leaders. As the leadership study across three Scottish health boards (Haycock-Stuart *et al* 2010, Kean *et al* 2011) indicates, followers do not simply follow – 'following' is an active, context-bound decision. This insight suggests dependence and reciprocity between leaders and followers and, more importantly, assumes the heterogeneity of followers.

Lack of insight into how followers follow has serious implications for our understanding of the leadership and followership processes.

The continuing belief that leaders are the only movers and shakers in organisations leads to a 'dependency to credit successful events to leaders, obscuring the significant contribution of followers' (Yukl 2010) and ignores the influence that followers have on leadership processes. If senior staff ignore followers and their contribution to leadership, they do so to the detriment of their organisations.

The paucity of research into followership suggests that there is a need to pay more attention to it as part of the leadership story.

Implications for practice

- Followers do not simply follow. Leaders in community nursing should be aware that successful leadership is the result of a co-constructive process involving leaders and followers.
- Leadership and followership are interdependent processes, yet the current focus of research continues to be centred on leadership. The integration of followers and followership into leadership research, and specifically into leadership and followership research that originates in the UK, is absent from the research canon.

Paying attention to these dimensions, namely, focus and location, would offer better understanding of how the leadership and followership processes interact and, therefore, how they contribute to better services.

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Conflict of interest
None declared

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