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A Leadership Model for Social Work: Drawing on Health Care to Inform Social Work Leadership

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Abstract

Leadership is a frequently used term, but these uses include various definitions and applications; these uses are sometimes contradictory. This definitional vagueness can be a particular challenge for professions, including social work. In comparison to other similar professions, there is a lack of leadership knowledge generation in social work. In addition, the organisational context in England has been challenging in recent decades, likely hindering development and application of leadership models. Health care has a broader empirical and conceptual development of leadership as a topic of examination. In health care literature, compassionate leadership is gaining momentum as a useful way of developing good clinical leadership. There is a strong tradition in social work of engaging with compassion as an element of social work values. We present models of compassionate leadership and consider their usefulness for the current social work knowledge base. We suggest that compassionate leadership may prove useful for social work practice and academia.

Keywords: clinical leadership, compassionate leadership, leadership, professional boundaries, social work

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Introduction

The importance of ‘leaders’ and ‘leadership’ now feature regularly in professional and academic discourse. These terms are often applied when considering the extent to which politicians have, or have not, shown good leadership in their areas of responsibility. Leadership is also discussed with regard to other spheres of public life, including business, sport and social justice. There is a general acceptance that good leadership is necessary if society is to respond to change, not least during the current COVID-19 crisis (Barton *et al.*, 2020). Despite our familiarity with these terms, there are many different ways to understand leadership, and there is no consensus about who are good examples of inspiring leaders. There are also some scholars that focus on leadership as practice (Carroll *et al.*, 2008; Raelin, 2017). To further complicate the concept, leadership can be facilitated by those in designated roles, but leaders also emerge in response to the particular challenge faced (Youngblood, 1997). Therefore, it is possible that a leader in one context could be a follower in another.

In addition to this definitional uncertainty, professions have particular complexities regarding leadership, with the effects of status and expertise, expectations of autonomy, and strong professional social norms. As professionals often more willingly follow leaders drawn from a similar profession, there has been considerable interest in how best to encourage and support professionals to take on formal and informal leadership roles. One way the social work profession has attempted to encourage uptake of leadership is via the Professional Capabilities Framework for social work in England (BASW, 2018) embedding leadership throughout a social worker’s career. However, unlike (and as discussed below) health care professions, social work has no agreed leadership model. There have been some connections made with generic theories such as ‘transformational leadership’ (e.g. Colby Peters, 2018) and ‘distributed leadership’ (Spillane *et al.*, 2004; Carpenter, 2015). The lack of an agreed leadership model creates complications for the social work profession in terms of developing its voice, knowledge base and response to external threats (these are outlined below). Social work is a recently developed profession compared to law and medicine, meaning these challenges has a relevance for this discussion. A clear differentiation has been made between social work and health care professions in Britain, suggesting a preference for person-centred approaches (this differentiation is not as clear in other contexts). Whilst this clear separation has helped develop a more holistic approach, it also means the profession does not benefit from the more significant funding and societal responses that health care experiences.

In this article, we present recent developments regarding social work in England, and the context in which leadership must be demonstrated. We then reflect on potential learning from health care, and in particular

health care professions, regarding leadership. The emerging model of compassionate leadership is seen as having particular relevance to and potential for social work.

Social work leadership in England

A range of policy reviews and scholars have identified the importance and challenge of providing effective leadership, including calls for leadership to be improved and for this to improve social work practice. In his now-famous review, [Laming \(2009\)](#) stated that the negative effects of poor leadership were frequently identified in serious case reviews. [Munro \(2011\)](#) argued leadership was required to change the service system to a 'learning and adapting culture' (p. 107) and that 'strong, skilled leadership at a local level' was 'critical to success' (p. 106). It is important to note that as a result of the recommendations of this review, the role of 'principal social worker' was developed. The purpose of this role is to link strategic decision-making with frontline practice ([DHSC, 2019](#)). Given that the profession is 'practice-based' ([IFSW, 2014](#)), a clear alignment between practice and service design and delivery is essential. However, the role of principal social worker is a relatively recent development, with varied philosophies and realisation of the role within different organisations. The challenging context for services is a significant factor affecting the provision of good leadership, with organisations often reacting to the external scrutiny with a 'defensive compliance culture' which is counter productive for positive leadership ([Turnell et al., 2013](#), p. 201).

Despite such initiatives, social work leadership remains poorly defined in England, without an agreed definition ([Hafford-Letchfield et al., 2014](#); [Sullivan, 2016](#)). In an attempt to address this, the authors developed a working definition of social work leadership, drawing on the expert opinion of senior academics, practitioners and policymakers. For a wider discussion of how this was developed, readers are encouraged to see our previous publication ([Haworth et al., 2018](#)). The definition developed is:

Social work leadership: the use of professional credibility, competence and connections to positively influence others in response to the interests and aspirations of people and families. Achieved through coproduction with communities, collaboration with other professionals, and constructive conflict [with] injustice and inequality, it can be demonstrated through formal roles and informal encouragement of colleagues. ([Haworth et al., 2018](#), pp. 31–32)

Social work education in England also gives little consideration to leadership ([Lawler and Bilson, 2013](#); [Taylor, 2013](#)). Social work programmes, therefore, should examine their engagement with the topic leadership ([Holosko, 2009](#)); similarly the professional bodies. As an

example of this oversight, the Health and Care Professions Council proficiencies do not include leadership (Colby Peters, 2018); whilst this is the previous regulator, this speaks to an ongoing gap.

Two models which have received some attention in social work are ‘transformative’ and ‘distributed leadership’, both of which are often mentioned in social work texts (Hafford-Letchfield *et al.*, 2014). ‘Transformational leadership’ has its origins in business studies and encourages leaders to use qualities like personal influence and intellectual drive to followers to change and innovate (Northouse, 2016). Social work can be suggested to align with this model as it suggests leaders transform through showing how they value and motivate employees (Martin *et al.*, 2010; Lawler and Bilson, 2013). Central to this model is a focus on transforming perceptions of staff, and encouraging staff to work towards both organisational and personal goals (Sullivan, 2016).

‘Distributed leadership’, in contrast, suggests developing shared purposes and values are a mechanism to improve organisations. This model deliberately engages with the situational nature of leadership, suggesting context is integral to shaping the activities of leadership. In this model, collaborations and ongoing improvement are important to develop authentic shared leadership (Spillane *et al.*, 2004; Carpenter, 2015).

What both of these models suggest is the importance of setting the agenda ‘from the top’ and they fail to adequately consider the tradition in social work of ‘bottom up’ approaches (Dodds and Paskins, 2011). In this article, we suggest drawing from other disciplines, namely health care, and applying the model of ‘compassionate leadership’ as a reasonable alternative for social work organisations. It is important to note that health care leadership is not without critique, often described as patriarchal and hierarchical (Wolf, 2017), and there is a significant divide between the health and social care sectors (Miller, 2016; Lévesque *et al.*, 2019), so it is unwise to uncritically draw from health care for solutions to social work issues. Given this challenging intersection, applying compassionate care to social work requires that the specific context for these organisations needs to be considered, as the setting differs significantly from health care, with specific challenges.

Context for social work leadership

The context has been challenging for social work organisations for at least the past decade, which has reduced the ability to attempt new models of leadership. Extensive modernisation programmes have taken place within the English public sector generally, to mirror how the private sector functions (Harvey, 2005; Ferguson and Woodward, 2009), with successive governments of both major parties enacting neoliberal policies. In addition, significant funding cuts have resulted in reduced provision of

local authority services (Cummins, 2018). For example, the policy of 'austerity' involved a reduction of funding for services of 49 per cent between 2010 and 2018, even though there was a significant 'increase' in demand for services during the same timeframe (NAO, 2018). Consequently, one in ten councils experienced financial difficulties, and the NAO (2018) concluded 'the current pattern ... is not sustainable' (p. 11). With a growing ageing population, adult social care is experiencing similar challenges to those of the National Health Service (NHS; NHS Long Term Plan, 2019). Throughout the budget reductions of the last decade, the percentage of older people in the population increased about 9 per cent (King's Fund, 2015).

The profession has experienced a significant amount of scrutiny over recent decades. This has included creating both the Social Work Task Force and Reform Board (Social Work Task Force, 2009; Social Work Reform Board, 2012), two child protection reviews (Laming, 2009; Munro, 2011) and two further reviews of social work education (Croisdale-Appleby, 2014; Narey, 2014). Successive parliaments have sought to reform social work, such as establishing and closing the College of Social Work (TCSW); developing a sector-wide Professional Capabilities Framework (PCF) and two separate Chief Social Workers (CSW) for adults and children's social work for professional leadership. This CSW created Knowledge and Skills Statements (KSS) for local authority social workers (Department for Education, 2014; Department of Health, 2014), and for practice leaders/supervisors in children's services (DfE, 2015). Lastly, a new regulator for social work in England, Social Work England, was recently established. The speed and scale of these changes have inhibited sustained improvement, as they were not embedded before further change followed.

Social work services have experienced significant recruitment and retention problems over the past decade, with knowledgeable, expert social workers leaving the profession (Hopkins *et al.*, 2014). The Department for Education reported that during 2017–2018, 59 per cent of children and families social workers had fewer than five years' experience in their role, and overall national vacancy and turnover rates were 16 per cent (DfE, 2019). Recent estimates suggest the turnover rate for permanent staff was 30.8 per cent, a 9.1 per cent increase from 2012 to 2013 (Skills for Care, 2020). This can result in practitioners with less experience being appointed to leadership roles even though they may lack the necessary knowledge and skills (Bliss *et al.*, 2014).

Given these contextual issues, it is suggested that services have, in response, become more risk-averse (Taylor-Gooby, 2000), which likely stifles innovation and developmental change (Brown, 2010). The implications of these issues for improving leadership are clear, with increased challenges resulting in risk-averse organisational behaviour, changes to leadership style will be challenging to consider and

implement. Altering a leadership style is likely to increase risk and a realistic potential of failure—which would have significant negative effects. Furthermore, there is evidence that social workers end up in positions of leadership because of length of service, and not because of aptitude (Iachini *et al.*, 2015; Sullivan, 2016).

With a context of consistent change, reduced funding and increased demand, significant retention issues (leading to less experienced practitioners with increased leadership expectations) and a punishing inspection regime, it is unsurprising there has been a struggle to apply new models of leadership in social work services. When considering these issues, they appear to combine to encourage social work to diverge from expertise-based leadership, which is encouraged in health care (Goodall and Pogrebná, 2015; Goodall, 2016). With the range of public inquiries, intensive regulator oversight, media storms and serious case reviews, it could be argued that effective crisis leadership is more important for British social work (Lawler and Bilson, 2013) than expertise-based leadership.

Clinical leadership in health care

In comparison to the limited but developing field of social work leadership knowledge, in the English NHS leadership, and clinical ‘leadership’ in particular have been areas of concern and interest for some time. This development of leadership as a central feature of NHS organisation can be traced back to the ‘NHS Plan’ (DH, 2000), which focussed on leadership as a solution to the organisational challenges facing the NHS (Ford, 2005; Currie and Lockett, 2007). A key assumption underlying this ‘turn’ to leadership was the need to involve clinical staff and doctors in particular in direct leadership of health care services (Blumenthal *et al.*, 2012; Swanwick and McKimm, 2012). The following section outlines the knowledge related to this, given its distance from the social work discipline in the UK. It will first describe relevant changes intended to alter how leadership was enacted in health care and then explore the policy drivers for these changes and the intersection of the clinical professions and leadership—central to the concept of compassionate leadership. Following this, compassionate leadership is defined, including its theoretical foundations.

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The need for effective leadership in health and social care is frequently highlighted in reports as a policy concern including the ‘Darzi Review’ (DH, 2008a) and the ‘Berwick Report’ (Berwick, 2013) both of which called for improved leadership. More recently the ‘Five Year Forward View’ (DH, 2014) identified clinical and local health care leadership as a priority if the NHS was to be successful. Leadership is a current issue of concern in health care as demonstrated by the emphasis given to it in ‘NHS Long Term Plan’ (DH, 2019) which states that ‘great quality care needs great leadership at all levels’ (p. 89). This has led some to argue that ‘engaging in leading and managing systems of health care—be it at the level of the team, department, unit, hospital or health authority—is a professional obligation of all clinicians’ (Swanwick and McKimm, 2012, p. 22). However, the extent to which leadership can be balanced with clinical work presents a significant challenge for practitioners.

Although focused on ‘senior leadership’ in the main, frequent reference is made in literature to the fact that many leaders have a clinical background. A third of NHS Trust chief executives have a professional clinical qualification (the vast majority, 63 per cent, as nurses; NHS Leadership Academy, 2018).

One of the reported problems in terms of engaging health professionals in leadership is that the focus on individuals’ clinical needs, which is at the heart of professional practice, makes it difficult for clinicians to consider the needs of the organisation as a whole or the wider NHS (Crilly and Le Grand, 2004). Another issue is that some clinicians have been uncomfortable with introduction of management approaches in health care which they believe has constrained their professional autonomy (Davies and Harrison, 2003). Advocating leadership (NHS-III, 2009) and involvement of clinical professionals (Ham and Dickinson, 2008), could perhaps be regarded as an attempt by policymakers to restore some level of autonomy by encouraging ‘ownership’ of leadership, including the use of financial incentives (Rodwin, 2004). Yet despite this recourse to clinical leadership as a solution to the challenges of health service delivery, putting into practice is problematic (Storey and Holti, 2012). This is because efforts to introduce clinical leadership are often

founded on underdeveloped definitions and take no account of the context and realities practice (Howieson and Thigarajah, 2011; Hewison and Morrell, 2014).

When clinical staff engage with leadership this helps improve the culture and improves quality, safety and the working environment (Mannion and Davies, 2018). This was reflected in the 'NHS Long Term Plan' (DH, 2019) which identified the need to 'strengthen and support good, compassionate and diverse leadership at all levels—managerial and clinical—to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand' (p. 79).

Compassionate leadership and clinical professions

A recent development in relation to leadership in health care has been a focus on compassionate leadership. It has been suggested that this is a fundamental enabling factor in creating a culture of improvement and radical innovation in health care that enhances the intrinsic motivation of NHS staff and reinforces their altruism and promotes a culture of learning (West et al., 2017, p. 1). Adopting a focus on compassion may have the potential to bridge the putative divide between clinical practice and clinical leadership. Central to all health and social care is compassionate care for patients and staff (Miller, 2016). This is not always the case, as demonstrated by the findings of the Francis Report (Francis, 2013). There is policy commitment to build improvement skills for staff at all levels, and develop compassionate, inclusive leadership (DH, 2017), but this requires considerable development work and research to underpin this form of clinical leadership.

Ensuring that leadership maintains a focus on a concept as complex as compassion is somewhat ambitious, however, it is contended that it is needed as a corrective to the corrosive effects of command-and-control leadership and incivility which have a negative impact on staff (Cambridge Health Network, 2018) and patient care (Armstrong, 2018). If the power of leadership in health care is to be harnessed, there is a need to develop and support clinical leaders (Imison, 2018). Compassionate, caring and inclusive leadership (Edwards et al., 2018) may be what health (and social work) needs, however, if this vision is to be realised then the approach needs to be developed, tested and evaluated to contribute to the evidence base for clinical leadership.

Emerging evidence suggests that compassionate care interventions should shape the role of health care leaders by enabling them in mobilising structural capacity to support improve relational team working of staff in frontline care staffing roles (Bridges et al., 2018), because the core purpose and priority of successful health care organisations is high-

quality compassionate care is the core purpose and priority of the organisation and its leaders (Dixon-Woods *et al.*, 2014). This requires a shift from reliance on organisational models of leadership, to making a sharper focus on compassion as the key determinant element of health care leadership, which involves better use of relevant evidence to enable clinical leaders to optimise the use of compassionate interactional styles of leadership, even when under pressure (Crawford *et al.*, 2014).

Compassionate leadership can have a positive impact on practice (Hewison *et al.*, 2018, 2019) and MacArthur *et al.* (2017) contend there is need for a strategic vision for compassionate care that recognises and values the role of relationships and invests in practice development and leadership at all levels, although they concede that the organisational infrastructure necessary to embed and sustain compassionate care amidst all the other health service pressures and priorities, is less clear. In contrast, there is evidence about what is required to construct compassionate leadership: organisations that have inspiring visions operationalised at every level; with clear, aligned objectives for all teams, departments and individual staff; supportive and enabling people management and high levels of staff engagement; learning, innovation and quality improvement embedded in the practice of all staff; and effective team working (West *et al.*, 2015). Meeting each of these requirements demands concerted effort and organisational focus. In recognition of this challenge, there have been some guides published: NHS England's (2014) guide; the National Forum for Health and Well-being at Work's (2017) 'toolkit' to enable leaders. A further 'call to action' in this vein is 'Caring to change How compassionate leadership can stimulate innovation in health care' (West *et al.*, 2017) which identifies compassion as the core cultural value of the NHS and is an enabler of innovation in health care. These demonstrate how leadership is context specific, because although the focus on compassion may appeal to clinical staff and others working in health care, when applied to social care, this approach will require some adjustment. It also indicates, how despite extensive leadership development activity in the past, the impact on practice is relatively modest (Hewison and Griffiths, 2004).

Conceptualising compassionate leadership

Theoretically, compassionate leadership has been based on a number of sub-processes of compassion. These include noticing, feeling and responding. Noticing another person's suffering is a critical first step, involving becoming aware of the suffering of the other. Feeling involves 'suffering with' the other person or empathising with his or her hurt, anguish or worry (Kanov *et al.*, 2004). Responding compassionately involves taking actions to ease or eliminate the other person's suffering

(Frost *et al.*, 2000). It has been suggested that the inclusion of responding, or actually helping the other, is crucial as this differentiates compassion from related concepts such as empathy (Atkins and Parker, 2012).

Compassion has been interpreted in many different ways (Singh *et al.*, 2018), often depending on the functions to which it is applied (Gilbert, 2017). This variety makes selection of a coherent leadership model appropriate for compassionate health care problematic (de Zulueta, 2016). Strauss *et al.*'s (2016) helpful review identifies common features of eight major definitions as involving awareness of someone's suffering; being moved by it (emotionally and, for some, cognitively); and acting or feeling motivated to help (Strauss *et al.*, 2016). In addition to being moved by suffering, compassion involves tolerating uncomfortable feelings as a result of such suffering, including tolerating feelings of distaste, frustration or anger (Strauss *et al.*, 2016). Finally, in some definitions, compassion involves recognising a commonality with the sufferer, acknowledging that as a fellow being we could also find ourselves in a similar position (Strauss *et al.*, 2016).

Two models have been proposed. The first presented here was developed by identifying the component elements of compassion and applying them as four components of compassionate leadership that enable problem-solving and innovation: attending, understanding, empathising and helping (West *et al.*, 2017). The second is a European model which combines compassionate leadership with cultural competence. It focuses on the basic principles, values and skills that a health care leader should have as a role model for staff in delivering compassionate and culturally competent care (Kouta *et al.*, 2019). These are considered briefly in the discussion as a starting point for building a model that could be applicable to social work practice.

Considering compassionate leadership for social work

The stimulus for writing this article was a desire to improve the knowledge base for social work leadership and to suggest some possible solutions. Our earlier work outlined what is known about this topic and identified some important knowledge gaps (Haworth, Schaub and Miller, 2018). If we are to apply one or both compassionate leadership models, it is helpful to consider their potential contribution to social work leadership. It is helpful to note that there have been recent discussions about the need to increase the position of compassion in social work (cf Tanner, 2020), and research has found that social workers perceive their profession was a 'compassionate vocation' (Lévesque, *et al.*, 2019). The Compassionate Leadership Model has four main elements; 'attending', 'understanding', 'empathising' and 'helping'. These suggest that social work leadership can be compassionate through; listening to others,

seeking understanding, attempting to find commonality, acknowledging others' pain and difficulty and, importantly, trying to help to improve the situation (West *et al.*, 2017; West and Chowla, 2017). It is useful to examine how these components relate to social work professional standards. Several link to the 'Professional Standards' of 'Social Work England' (2020). 'Attending' and 'understanding' align almost verbatim with Standard 2 (particularly 2.5), to 'establish and maintain the trust and confidence of people', whereas 'empathising' and 'helping' link to Standard 1, which requires that social workers 'promote the rights, strengths and wellbeing of people, families and communities'. It seems reasonable that this model has some synergies with social work values (Hafford-Letchfield, 2019).

Moving on to envisage how this model may benefit social work leadership, our earlier work (Haworth *et al.*, 2018) presented a cycle of 'missing' social work leadership, developed based on the insights of leaders in academia, policy and practice.

The 'helping' element could partially address social work education issues identified early in this Figure 1; namely, the lack of leaders and leadership content from social work education. This element would connect with a drive to contribute the next generation of professionals, and

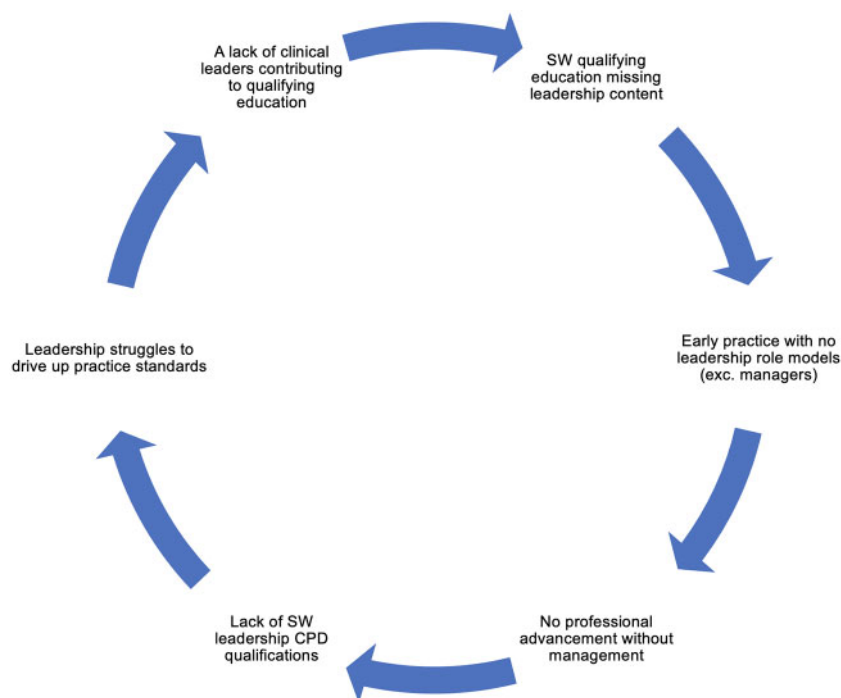


Figure 1: A conceptual model of missing leadership in social work (from Haworth *et al.*, 2018).

social work education would be improved by additional contributions. The further three elements of ‘attending’, ‘understanding’ and ‘empathising’ could be applied in practice settings, specifically in highlighting the need for managers and other leaders to listen to their colleagues and service users. The need for practice-focused routes to promotion has been identified (Munro, 2011), and the development of the Principal Social Worker role has been created in response to this need (Stanley and Russell, 2014). Listening to staff and clients and making changes based on these discussions could create an impetus for service improvements in the practice setting. Anti-oppressive social work literature recommends a strongly person-centred approach, expending significant effort to hear, understand and implement service users’ needs and wishes (Burke and Harrison, 2002). This framework aligns well with this model with the application of a strong engagement with those that use services, as well as connecting to the practice-led orientation of the profession (IFSW, 2014).

The compassionate leadership model has been applied to the health service organisations with an aim to improve innovation, from individual to system-wide factors (West et al., 2017).

Level	Compassionate leadership activities	Cognitive/emotional processes	Other processes
Individual	Listening Role-modelling reflexivity Coaching	Self-efficacy Self-worth at work Good relationships	Suggesting Noticing opportunities Trying, failing, learning
Team	Creating a psychologically safe environment Discovering meaningful differences and similarities Facilitating purpose	Psychological safety Appreciating each other Team identification	Discussion Review and implementation Team efficacy and potency
Inter-team	Exchanging information empathically Role-modelling perspective-taking Building awareness of mutual needs and interdependence	Multi-level perspectives Organisational identification Diversity matters	Lower inter-team conflict Higher inter-team collaboration Higher-quantity and higher-quality innovation
Organisational	Having a realistic vision Creating a culture of belonging Personalising purpose Using strategy as practice/a learning process	High levels of inclusion Secure attachment/high organisational identification	Organisational agility and responsiveness Organisational resilience Faster adoption of innovation
System-wide	Showcasing compassionate leadership practice Using strategy as a reflective learning process	Embracing failure as human and an opportunity for improvement System resilience Adopting a learning perspective	System-wide learning Robustness/resilience Faster diffusion of innovation

Source: West et al. (2017, p. 6).

The application of this model for innovation may help to address some of challenges of social work leadership. Beginning at the individual level, the suggestion for all practitioners (this model calls them ‘clinicians’) to have a responsibility for both listening as well as modelling and coaching. Modelling and coaching could help to address the ‘unhooking’ that has resulted from practitioners feeling divorced from leadership of social work and social care services (Munro, 2011). Each level includes the opportunity and encouragement to try innovations, and to accept failure as an expected outcome. This last aim, allowing failure, could address some of the challenges resulting from risk-averse practice (Carey, 2014). ‘Attending’ and ‘empathising’ are necessary for this application to be successful, as they can develop shared understandings and connectedness—these are represented in the above table repeatedly (e.g. ‘building awareness of mutual needs and interdependence’).

This model and application have not previously been applied to the social work/social care context and, as outlined earlier in this article this is a significant consideration for this service arena. It may be helpful to consider the concept of ‘containment’ to help address the churn and strain of the context, as well as to suggest that ‘leaders, courageous enough to take up their authority in an emotionally engaged manner, can reverse these dynamics to the relief and benefit of all concerned’ where the style of the leader ‘is communicated to staff, who in turn pass it onto clients’ (Foster, 2013, p. 119). Whilst originally from psychoanalytic theory, this concept has been applied more widely in social work (cf Ruch, 2005) with some success.

Another model worthy of consideration is the European model for developing culturally competent and compassionate health care leadership (Kouta *et al.*, 2019). This empirically based model has four components:

1. Culturally aware and compassionate health care leadership
2. Culturally knowledgeable and compassionate health care leadership
3. Culturally sensitive and compassionate health care leadership
4. Culturally competent and compassionate health care leadership (IENE, 2014; Kouta *et al.*, 2019).

The model focuses on particular skills and competencies leaders need to develop (Figure 2).

However, it also includes clear statements about the need for particular values and knowledge to underpin culturally competent and compassionate leadership. The outcome of a collaborative European research project, its developers argue that it provides the theoretical and practical components needed for the development of culturally competent and compassionate health care leaders. Its primary purpose is educational as it ‘can be used as a conceptual map for potential content to help health

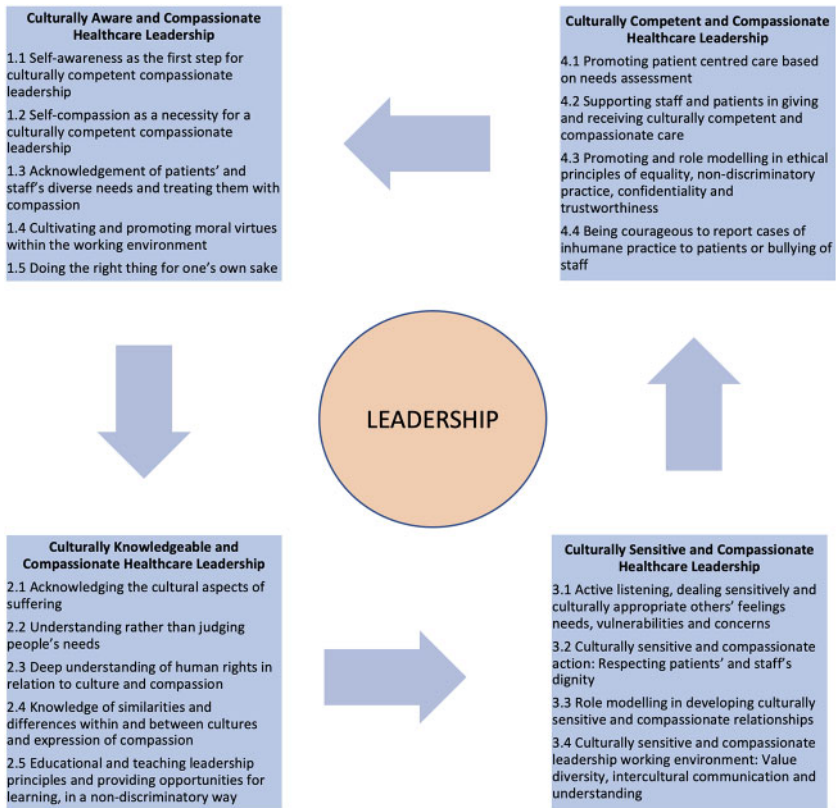


Figure 2: A European model for developing culturally competent and compassionate health care leadership (from <http://ieneproject.eu/compassion.php>).

care trainers in the development of educational programs and educational tools for senior health care professionals, who are considered important links in the development and establishment of culturally competent and compassionate caring health care environments' (Kouta *et al.*, 2019, p. 116). This would seem to be worthy of consideration for the development of education programmes in social work leadership.

Conclusion

This article examined the critical challenges for developing and implementing social work leadership. It outlined the challenging context, which has produced risk-averse services and has significant implications for attempting to introduce new modes of leadership. Two models of 'compassionate leadership' have been presented as potentially useful approaches to apply to the social work/social care context. One model

was applied to a cycle of missing leadership, with suggestions for how it may assist social workers and social care organisations to more adequately meet the challenges of instilling leadership throughout the various strata of the profession. In particular, the application of compassionate leadership aligns with social work values, and the focus on cultural competence in the second model considered is likely to be of particular interest to social workers. Given the more robust examination and application in health care literature and research, it is useful to consider the knowledge generated from the health care disciplines. Finally, with renewed interest in the benefits of inter-professional collaboration as a means to better integrate care around individuals and families, a common leadership approach based on compassion may be a powerful enabler to support joint working between health and social work (Miller, 2019).

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