MASTERCLASS PAPER

Leadership for Primary Health Care Research

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Over the last decade, I have put together a new theory of leadership. This paper describes its four propositions, which are consistent with the research literature but which lead to conclusions that are not commonly held and seldom put into practice. The first proposition is a model describing the territory of leadership that is different from either the Leadership Qualities Framework, 2006 or the Medical Leadership Competency Framework, 2010, both of which have been devised specifically for the NHS (National Health Service). The second proposition concerns the ill-advised attempt of individuals to become expert in all aspects of leadership: complete in themselves. The third suggests how personality and capability are related. The fourth embraces and recommends the notion of complementary differences among leaders. As the NHS seeks increasing leadership effectiveness, these propositions may need to be considered and their implications woven into the fabric of NHS leader selection and development. Primary Health Care research, like all fields of collective human endeavour, is eminently in need of sound leadership and the same principles that facilitate sound leadership in other fields is likely to be relevant to research teams.

Key words: leadership; models of leadership; NHS; Primary Health Care research

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Introduction

During, or immediately after, times of turmoil, the thoughts of lay people and researchers alike turn to the subject of leadership. Our current turbulent times are no exception. Lay people seek explanations for what is happening around them and tend to attribute causality in the form of blame to those they consider to hold leadership positions. We cannot possibly have caused our own problems as a nation, attribution theory would suggest, it must be someone's fault. Researchers cast a more sanguine and dispassionate eye on the situation but also seek to understand how it is that certain people are followed and others are not; why certain leaders are more effective than others; and what lessons may be learned from successes and failures of leadership.

Over the last decade, I have put together a new theory of leadership (Pendleton and Furnham, 2012). This paper describes its four propositions, which are consistent with the research literature but which lead to conclusions that are not commonly held and seldom put into practice. The first proposition is a model describing the territory of leadership that is different from either the Leadership Qualities Framework (LQF) (2006) or the Medical Leadership Competency Framework (MLCF) (2010), both of which have been devised specifically for the National Health Service (NHS). The second proposition concerns the ill-advised attempt of individuals to become expert in all aspects of leadership: complete in themselves. The third suggests how personality and capability are related. The fourth embraces and recommends the notion of complementary differences among leaders. As the NHS seeks increasing leadership effectiveness, these propositions may need to be considered and their implications woven into the fabric of NHS leader selection and development.

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The NHS leadership frameworks

Most organisations hold beliefs about their uniqueness that drive them into creating tailored models and frameworks rather than adopting frameworks created elsewhere. Yet it is not the organisation that responds to leadership but its people. Unless the people of the NHS are somehow different from people in other organisations, it is unlikely that a unique framework is required. We are seeking to build our understanding of leadership on the subject of psychology, which seeks to understand the operating system for homo sapiens rather than the quirks of some clinical subspecies, and it is my firm view that leadership of clinicians, medics and Professions Allied to Medicine is likely to be entirely consistent with the leadership of other groups: consistent but not identical. Thus, every organisation requires some specific understanding of its history, purpose, context, values and aims in order to lead it well but the same overall principles probably apply.

The two previous attempts to create unique models for the NHS are illustrated here. Each blurs the distinction between leadership and management: helpfully in my view, as both leadership and management are required in order to facilitate action and are, largely, inseparable if an organisation is to thrive. Yet neither framework seems to know what to do with personal qualities.

Somehow, we know that certain qualities will help us lead well but how do we deal with those whose personal qualities are different? There is good evidence, for example, that extraversion is the single most powerful predictor of both being appointed to leadership positions and also being effective in them (Bono and Judge, 2004; Hogan and Kaiser, 2005; Derue *et al.*, 2011). But personal qualities are attributes and thus not of the same nature as capabilities in, for example, managing a service, contrary to the statements at the centre of the LQF. Extraversion is associated with engaging with people and also with being forceful (assertive), both of which are generally associated with being an effective leader. Yet the effect of personal qualities is largely to determine aspects of leadership style and approach, which, combined with other capabilities, determines the leader's impact and effectiveness (Figure 1).

Both frameworks contain such elements as setting direction and delivering the service, yet each contains a different core element (personal qualities versus delivering the service). The LQF seems to distinguish between 'personal qualities' (eg, self-belief and personal integrity) and other human qualities such as intellectual flexibility and drive for results. These are all attributes and hence personal qualities. It also separates into different domains such matters as political astuteness and strategic influencing. Are these not fundamentally linked?
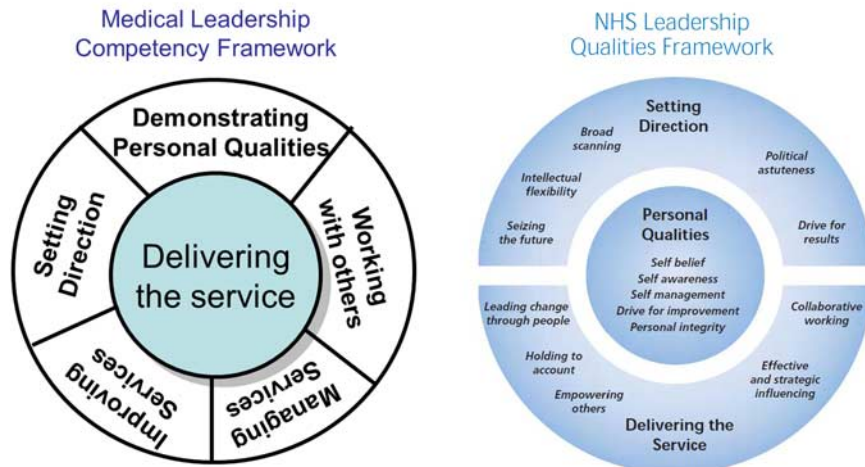

Figure 1   NHS leadership qualities and medical leadership competency framework

The MLCF has fewer elements than the LQF, but still it distinguishes between managing the service and improving the service. These are two sides of the same coin as most managers will regard what the model refers to as 'service continual improvement' as a fundamental part of managing the service. In addition, the framework says nothing about the relationships between its elements. Are we to take it that managing the service is more closely related to working with others than it is to setting direction? Both frameworks seem to be loose aggregations of disparate elements all of which are thought to have a relationship with leadership.

More recent thinking

My colleagues and I have striven to handle these matters differently. First, we have started with the evidence. What does the evidence say about the impact of leadership and the components of more, rather than less, effective leadership? Second, we have tried to identify what leaders actually have to do: a task-based approach that seeks to avoid mixing different types of leadership components. Indeed, we follow Hogan and Kaiser (2005) in imagining a sequence in which the personal qualities of the leader affect leadership style, which brings about a series of effects that ultimately result in outcomes that are preferred. Thus, effective leadership process is defined in terms of the achievement of desirable outcomes. This is precisely the approach other colleagues and I took with the identification of tasks for effective consulting with patients in general practice (Pendleton *et al*., 1983; 2003). We defined effective consultations as those that achieved certain tasks that led to positive short-term, medium-term and longer-term outcomes.

Pendleton and Furnham (2012) have reviewed the research literature on the effect of leaders on organisations' performance. Citing a number of meta-analyses, the authors reiterate the repeated finding that, in the commercial world where outcomes are relatively clear, leadership differences account for 13–15% of the variance in the performance of organisations and substantially more if time-lag effects are taken into account.

Yet Pendleton and Furnham also describe the work of Wasserman *et al*. (2010) who asked *when* does leadership make a difference? In this major study, the authors examined data from over 10 000 observations (from 531 companies over 19 years) and concluded that the 'CEO effect' was significant, accounting for around 14% of the variance in company performance, but they also noted that this effect varied between different types of business. In some types of business, the CEO effect accounted for just 2% of the variance (Meat Products, Commercial Banks), whereas in others it accounted for 21% of the variance (Communications Equipment). They concluded that 'focussing on the contexts where leadership matters appears to be perhaps a more productive line of enquiry than simply asking whether leadership matters.' (p. 56). The difference seems to be accounted for, in part, by situational issues such as the availability of opportunities and the resources by which they can be pursued, but possibly counter-intuitively. Leadership has the biggest impact when the opportunities are *fewest* and the resources to explore those opportunities are *scarcest*. To put it simply: in the good times leadership makes a small positive difference but a huge impact when times are hard (though organisations frequently sow the seeds of their later demise in the good times when they relax necessary disciplines).

What do leaders have to do to make a difference? The literature on this topic is extensive and there is not space in this paper to review it. Pendleton and Furnham (2012) make a start though they cover it briefly. It is clear, however, that the impact leaders have on results is not direct but indirect. Leaders influence the culture and climate in an organisation: the conditions under which people work, which, in turn, has an impact on the degree of commitment people feel to the organisation. This effect is usually described as 'employee engagement' and on this, the literature is clear, whether examining evidence from large or small organisations and public or private sector: higher levels of employee engagement are associated with lower employee turnover, absenteeism and theft from the organisation, lower levels of accidents, greater productivity and greater employee satisfaction (Harter *et al*., 2006; Macleod and Clarke, 2009). Yet there is a perception gap at the heart of UK leadership and management in which managers overestimate their effectiveness relative to the perceptions of their employees. In a 2012 survey, the UK's Chartered Institute of

Personnel and Development (CIPD, 2012) found that 80% of managers think their people are satisfied or very satisfied with them as a manager but fewer than 60% of their people agree. Over most aspects of management and leadership, the CIPD research demonstrated a significant contrast between how managers say they manage their people and the views of their employees. Similarly, Cowell (2012) found that only around one in three UK managers considered their organisations to be in good hands, the majority believed that increasing the quality of their leadership would boost performance, but only 4% believed it was a top priority to address this situation and only 17% had confidence that the most appropriate actions were being taken to do so.

These effects are also striking in the NHS. Beverley Alimo-Metcalfe *et al.* (2008) demonstrated that engaging leadership predicted productivity, morale and even the health of the team members more powerfully than competencies. Their engagement model included, at the heart of engagement: acting with integrity and being honest and consistent. The other elements were:

- *engaging individuals* by being accessible, showing genuine concern, enabling and encouraging questioning;
- *engaging the organisation* by supporting a developmental culture, inspiring others, focusing team effort and being decisive;
- *moving forward together* by building shared vision, networking, resolving complex problems and facilitating change sensitively.

Engaged individuals repay the investment made in them by giving back more of their discretionary effort. This effect was first noticed in a series of articles in the Harvard Business Review in the 1990s under the general theme of The Service-Profit Chain or the employee–customer profit chain (Rucci *et al.*, 1998). It has become a key element of leadership thinking that leaders create the conditions in which people love to work and the people repay them by turning up to work more regularly, being more productive while they are there and staying in post longer.

A new theory of leadership

In order to do justice to the latest research on engagement, we have sought to construct a new

theory of leadership. There are four propositions in our theory but the general core idea is summarised in our definition of leadership: leadership is creating the conditions for people and organisations to succeed and achieve significant goals.

Proposition 1: the Primary Colours of leadership

The first proposition is that leadership's territory covers three domains: the strategic, the operational and the interpersonal. Visualise these domains by reference to a human being:

- The *strategic* domain acts like the head: it makes sense of what is going on, envisages the organisation's future and creates plans to take it forward. Its principal capability is intelligence, both fluid and crystallised.
- The *operational* domain represents the hands and legs: it gets things done, achieves results and drives the organisation forward. Its principal capability is determination or will power.
- The *interpersonal* domain is like the heart: it is where feelings reside and relationships are maintained. Its principal attribute is the ability to form and sustain relationships: occasionally called emotional intelligence.

We have dubbed this the Primary Colours of leadership as we propose that most leadership competencies are made up from these three underlying capabilities. It is illustrated in the diagram here. This image provides a way of visualising these three areas or domains in terms of overlapping circles, each of which is represented by a different Primary Colour. These are arranged as a Venn diagram to show the relationship between the elements, which are defined as tasks (Figure 2). These are:

- *Setting strategic direction*: Defining the purpose and direction of an organisation, its vision, mission, values and strategy. Strategic thinking also concerns radical and original thinking and sound analysis of contextual issues in addressing the organisation's future.
- *Creating alignment*: Securing understanding of, and commitment to, the organisation's purpose and strategy. The same task may also relate to the building of commitment to specific programmes and initiatives. This is a matter of

Figure 2 The Primary Colours of Leadership

influence and persuasion whether individually, in teams or in larger groups.

- *Building and sustaining relationships*: Forming robust and effective working relationships with all key stakeholder groups. This includes building and maintaining trust, credibility and goodwill.
- *Team working*: Working well and getting things done in teams. Teams include working in hierarchical teams with manager and subordinates, peer groups and *ad hoc* working groups and project teams. At a senior level, this will also include creating and disbanding teams and helping them work effectively.
- *Delivering results*: Driving individuals, teams and organisations to deliver the results they need to achieve. This involves overcoming opposition and injecting pace and urgency into performance. It has a hard edge of insistence and assertion and a strong will to succeed.
- *Planning and organising*: Putting in place structures, plans and processes that keep people focused on priorities and clear about how to deliver the organisation's goals. This includes establishing and using follow-up and review processes and mechanisms for dealing with unexpected events, balancing the integrity of the plans and processes with flexibility in the face of potential derailers.
- *Leading*: Leading is most importantly ensuring that the right leadership contribution is made in any given circumstances. This is the primary leadership task and may well involve allowing others to lead when their leadership abilities are stronger than one's own for the circumstances.

It matters that trust and commitment are inspired; efforts are focused; individuals and groups are enabled; the right behaviours are reinforced; and that individuals and groups are helped to learn. It does not matter who achieves these things.

Proposition 2: it is hard to be highly competent in all three leadership domains

Pendleton and Furnham (2012) have argued that it is hard for an individual to be exceptionally skilled in all aspects of leadership. They made the case from a theoretical and logical basis, but the essence of this proposition is the empirical observation that in many hundreds of psychologically based leadership assessments carried out over more than 20 years, we have never yet found a leader who is individually complete and practising at the highest level in all leadership elements. They also pointed to the finding that there are aspects of personality that help in some aspects of leadership and hinder in others. Openness, for example, seems to help in the strategic domain but hinder in the operational domain where the key to success is to focus.

Proposition 3: personality and capability combine to identify natural strengths, potential strengths, fragile strengths and resistant limitations

It has long been the assumption of managers and educators that all limitations, once identified, should be developed to seek improvement. This may not be wise. Personality is slow to change and yet it is involved in creating capabilities and sustaining performance. The diagram here describes the distinction we are making between strengths and limitations, on the one hand, and personality's helping and hindering factors, on the other (Figure 3).

A Natural Strength is supported by personality. Consider the ability to plan and organise, which some can practise to a high level and others cannot. This is learned but may be supported by the personality attribute of conscientiousness, which is associated with being systematic, ordered and disciplined. When a conscientious person tackles any complex task, his or her first reaction is to do so in a systematic manner which usually

Personality and competence
Competence

	STRENGTH	LIMITATION
PERSONALITY HELPS	*Natural strength*	*Potential strength*
PERSONALITY HINDERS	*Fragile strength*	*Resistant limitation*

Figure 3 Personality and competence

Colleagues' complementary differences

Natural strength	Potential strength	Person A
Fragile strength	Natural strength	Potential strength
	Fragile strength	Resistant weakness

Person B

Figure 4 Colleagues' complementary differences

involves planning and organisation. These two factors are mutually reinforcing such that the conscientiousness is likely to be a consistent source of help in planning and organising even when the individual is tired or not attending closely to the task in hand.

A strength that is unsupported by personality is Fragile. Thus, the individual who has learned to plan and to organise but who is not conscientious has a clear skill but may need always to focus deliberately on the task in order not to become disctracted or to tackle it in an indisciplined, suboptimal way. By contrast, a conscientious person who has not yet learned how to plan or organise well should be able to do so quickly. The potential to do well at this capability is carried by the conscientious personality just as a Bridge player may have been dealt a strong hand of cards but has not yet learned how to play it well. Such learning, combined with a strong hand, should lead to rapid success.

Finally, the world of professional practice is littered with people who have been beating their heads against brick walls for years: trying to learn those skills and capabilities that they seem hard wired not to do well. They can make progress but it is slow and painstaking and the effort may frequently be questioned. These people are operating in the area of Resistant Limitations.

Now these distinctions enable a smart series of responses to be made by those interested in professional development. We can encourage those with Natural Strengths to use them. We can encourage those with Potential Strengths to develop them. We need to encourage those with Fragile Strengths to recognise their fragility and continue to work on them. Those with Resistant

Limitations may be better advised to work around them than to work on them directly. Working around a Resistant Limitation does not mean abandoning it but rather finding opportunities to achieve one's goals by working with others whose skills and capabilities are different from our own.

Proposition 4: complementary differences

Proposition 3 implies proposition 4: that we can best create complete leadership by leading with others whose capabilities complement our own. This means emphasising diversity and team-based leadership rather than the leadership of individuals. The principle is best illustrated in the diagram here of colleagues' complementary differences. In the diagram, Person A has chosen to work closely with Person B whose Natural Strengths are in the area where Person A displays Resistant Limitations. This is the essence of teamwork and makes the case for the benefits of diversity without recourse to political correctness (Figure 4).

Diversity is the key to effective teamwork and more complete leadership. Thus, the leader who inspires will often find that the intuitive and impassioned personality is ill suited to more bureaucratic endeavour, or the natural strategist frequently overlooks the detail required to excel operationally. Thus, the leader who is strong in creating alignment may need a colleague to organise him/her; the strategist needs the operator. Medical appraisers may be tempted to encourage individuals to work on all their limitations but,

depending on whether these are helped or hindered by personality, it may be better advice to help appraisees find sound 'work around' solutions.

What has this to do with the primary care researcher?

First, researchers are involved in the development of ideas and the testing and refinement of practice. This is a leadership role and it has several manifestations. The researcher of disease and treatment effectiveness helps colleagues deliver results. The researcher who also develops theory is engaged in helping set direction through the development of ideas and policies: they are opinion leaders. The researcher in community medicine may help formulate strategy directly. Our theory suggests it may be important to consider the leadership impact of research and development in order to maximise it.

Second, it may also be important to consider how research teams are led. Primary Health Care research, like all fields of collective human endeavour, is eminently in need of sound leadership and the same principles that facilitate sound leadership in other fields is likely to be relevant to research teams. Strategic direction still needs to be set, alignment created, plans made and so on. Who makes these various contributions, and how is the leadership to be made more complete and more effective? Such matters ought not to be left to chance.

Third, continuing research into the impact of medical and clinical leadership is much needed. At times when the provision of health services is under scrutiny and the affordability of the services is under constant review, the potential of leadership to enhance effectiveness is eminently amenable to research and development and may fill the gap in our understanding, for example, of the leadership that is most effective in primary care. How does it need to be adapted and tailored to fit the peculiar needs of partnerships, multi-professional teams and community involvement? There is a great deal still to be done from a research perspective to help work out how to apply sound leadership principles to specific health service contexts.

Change is a constant in the NHS. New governments bring new reorganisations with almost inevitable regularity. Primary Care is moving inexorably centre stage. Primary Health Care research has a clear opportunity to inform, evaluate and shape the effectiveness with which these changes are led. Perhaps now is the time for Primary Colours in Primary Care.

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