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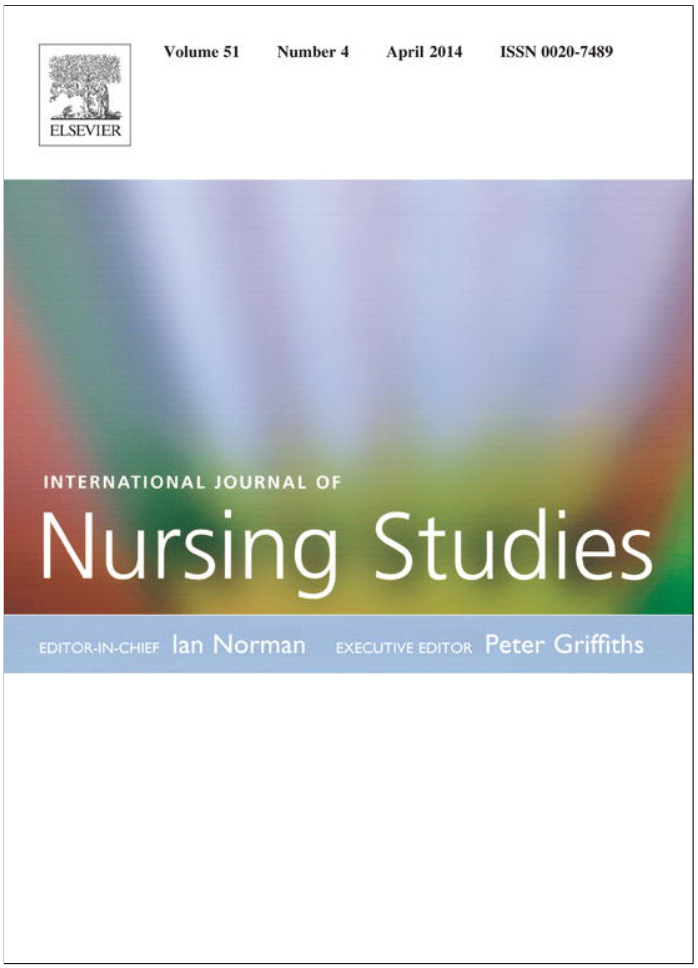

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Leadership development in the English National Health Service: A counter narrative to inform policy

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ABSTRACT

Objectives: To examine the current approach to leadership development in the English National Health Service (NHS) and consider its implications for nursing.

To stimulate debate about the nature of leadership development in a range of health care settings.

Background: Good leadership is central to the provision of high quality nursing care. This has focussed attention on the leadership development of nurses and other health care staff. It has been a key policy concern in the English NHS of late and fostered the growth of leadership development programmes founded on competency based approaches.

Design: This is a policy review informed by the concept of episteme.

Data sources: Relevant policy documents and related literature.

Review methods: Using Foucault's concept of episteme, leadership development policy is examined in context and a 'counter narrative' developed to demonstrate that current approaches are rooted in competency based accounts which constitute a limited, yet dominant narrative.

Conclusion: Leadership takes many forms and varies hugely according to task and context. Acknowledging this in the form of a counter narrative offers a contribution to more constructive policy development in the English NHS and more widely. A more nuanced debate about leadership development and greater diversity in the provision of development programmes and activities is required. Leadership development has been advocated as being crucial to the advancement of nursing. Detailed analysis of its nature and function is essential if it is to meet the needs of nurse leaders.

What is already known about the topic?

- Leadership development is necessary for effective nursing leadership.
- Relational and empowering leadership has been found to be effective in nursing.
- Leadership development is largely competency based.

What this paper adds

- The use of the concept of episteme reveals the limitations of competency based approaches to leadership development.

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- There is an evidence base demonstrating the limitations of competency models that is overlooked for policy purposes.
- The development of a counter narrative is a useful corrective to current leadership development policy.

1. Introduction and background

The need for leadership in, and of, the National Health Service (NHS) has been a recurring theme in English health policy in recent years (DH, 2000, 2008a,b, 2009a,b). This can be seen as the latest in a series of initiatives designed to engage clinicians more directly in the management of the NHS (Glennerster et al., 1994; Harrison et al., 1992; Huxham and Bothams, 1995; Packwood et al., 1991). The latest example of policy development in this area is the establishment of the NHS Leadership Academy with its mission to develop outstanding leadership, in order to improve people's health and their experiences of the NHS (NHS Leadership Academy, 2013). However the leadership challenge for nursing is not confined to the English NHS, for example the International Council for Nurses (ICN) has a vision that Nursing in the 21st century will have nurses at a country and organisational level equipped with the knowledge, strategies and strength to lead and manage in health services and in nursing through change for a healthier future for all populations (ICN, 2013). This indicates that leadership, and its impact on nursing and patient care, is of international concern (Bishop, 2009; Freshwater et al., 2009). Furthermore detailed consideration of a range of theoretical insights is vital if policy in this area is to be appropriate and result in approaches to leadership development that improve the quality of leadership and patient care.

The purpose of this paper is to examine this development in the context of the instrumental logic which has informed English health policy of late, and contrast it with the normative logic (Brown, 2008; Taylor-Gooby and Wallace, 2009) evident in the literature that discusses leadership development in health care, and consider its implications for nursing. The intention is to make a contribution to the burgeoning literature which has examined leadership in nursing (see for example Cummings et al., 2010; Laschinger et al., 2011; MacPhee et al., 2011; Salmela et al., 2012; Stewart and Usher, 2010) and demonstrate how the application of an aspect of theory can illuminate important issues with regard to leadership.

To do this we use the concept of *episteme* (Foucault, 2002). An episteme is a collectively internalised logic or 'code of culture' (O'Leary and Chia, 2007, p. 392); a set of interconnected, typically unspoken assumptions that both describe and bring into being social phenomena. Epistemes make the social world because they create particular kinds of subjects and categories, and in doing so they justify the use of power and, ultimately, support different kinds of violence. Most influentially, Foucault (2001, 2002) studied epistemes in relation to the invention of madness and the label, 'insane'; the nature of academic knowledge and disciplines, and a range of other topics. Spivak (2009) describes how an episteme of imperialism makes the colonial subject into someone that is regarded as 'other', demonstrating the effect that such assumptions can have. Epistemes have been used to describe organisation-level settings too, for instance O'Leary and Chia (2007) described how epistemes supported sense-making at a family-owned newspaper.

Here we describe the effects of a policy episteme – relating to 'leadership' in healthcare. This episteme results in a narrative about leadership that is theoretically thin and simplistic. It produces a certain view of leadership – as based on a dominant competency account – that neglects complexities such as the interrelationship between the context for leadership and individual leaders. This in turn influences approaches to development. We suggest that the complexity of NHS leadership cannot be adequately conveyed unless alternative accounts are also accessed. To demonstrate this, and develop a counter-narrative of NHS leadership development, we draw on Grint's (2000) fourfold typology of approaches to representing leadership, (see below). Each typology generates different insights on the nature of leadership, and this raises questions about how leadership development is being pursued in health care. The identification of this counter-narrative is important in order to counterbalance the prevailing competency-based, instrumental approaches to leadership in contemporary policy (Bolden and Gosling, 2006; Bolden et al., 2006). This approach could also be applied more widely to inform debates about how best to approach nursing leadership development in other settings. For example in Ireland it has been argued that greater attention needs to be given to interdisciplinarity (Fealy et al., 2011), and in Turkey development based on a model of transformational leadership has been advocated (Duygulu and Kublay, 2010). Similarly, in Canada, an empowerment framework for development has been recommended (MacPhee et al., 2011), which suggests that a variety of approaches need to be considered and evaluated.

The paper is divided into five main sections. First, we offer a brief review of leadership in health care in England to provide a context for the discussion. Second, we summarise the principal approaches to the development of leadership capacity in health care, launched as part of *the NHS Plan* (DH, 2000) and given further impetus in the Darzi Review of the English NHS (DH, 2008a,b, 2009a,b), and most recently culminated in the establishment of the NHS Leadership Academy. This illustrates how the leadership development challenge is being addressed. Third, we present a summary of the major theoretical strands in the leadership literature and argue that the current perspective on leadership development in English healthcare is but one episteme, which has emerged as an attempt to impose order on an inherently complex area of policy development. Finally we argue for a more nuanced picture of the reality of leadership development and greater diversity in the provision of development programmes and activities for nurses. Acknowledging that leadership takes many forms and varies hugely according to task and context, offers a more constructive platform for policy development in complex healthcare organisations (Fairhurst, 2009; Grint, 2010).

2. Leadership in the English National Health Service

With an organisation as large and complex as the National Health Service (NHS) there is always a risk in attempting to summarise aspects of its history. Indeed drawing any general conclusions about its leadership and management is fraught with difficulty because there are so many factors to take into account including tradition, the power of the professions, the legacy of structural changes, successive reforms, and different ideologies. Notwithstanding these caveats, the shift in policy focus to 'leadership' and 'leadership development' in the NHS occurred comparatively recently (Edmonstone and Western, 2002), and gained momentum following the publication of *the NHS Plan* (DH, 2000) (Currie and Lockett, 2007; Ford, 2005).

The organisation of the NHS can be characterised as moving through four major phases (Mannion et al., 2010) which summarise the formal structures in place at specific periods of time, which in turn determined in part the emphasis given to leadership. These phases provide a broad framework for charting the emergence of leadership development as an organisational concern, and as we argue in the second section, can be understood in terms of the Foucauldian concept of episteme – implicit logics that govern what constitutes legitimate knowledge, and that structure inference and action in social settings (Foucault, 1973, 2002).

2.1. From the beginning: 1948–1983

Although relatively little academic social scientific research into NHS organisation occurred until the mid 1960s (Mannion et al., 2010), extensive histories have been written about this period (see Webster, 1988, 1998 for example) which indicate that the service was run on the basis of supporting the health professionals to deliver care and treatment, thus the emphasis was on administration rather than leadership. The managers were 'diplomats' (Harrison, 1988) who ensured the professionals were able to treat and care for patients in the way they saw fit. Nursing was focused on professional care and aside from the Matron role had little involvement in leadership in a formal sense (Clarke, 1995). This is not to suggest that nurses were not engaged in departmental and team leadership in delivering clinical care, rather to indicate that at a policy level organisational leadership was not an overriding concern. Two of the major policy reforms of this period, the Salmon Report (MOH, 1966) and the 1974 reorganisation (DHSS, 1974), reflected this emphasis on management structures and organisational control. For example both of these reports drew on 'systems theory' (Scott, 1961) to an extent in recommending that the different elements of the service and the levels of nursing organisation needed to be sub-divided, and managed as separate units if they were to be effective. In nursing this resulted in a hierarchical structure being developed in which seniority was designated numerically. So a number 7 was a 'nursing officer', senior to a ward sister, and a number 8 was at the next level in the nursing organisational pyramid.

2.2. General Management and a new performance regime: 1984–1990

In the wake of the publication of the *Griffiths Report* (DHSS, 1983), private sector management approaches were introduced primarily in the form of the new 'General Managers', who were intended to be the equivalent of the chief executives in commercial companies. There was considerable opposition from the Royal College of Nursing to the changes proposed by *Griffiths*, however the recommendations were implemented in full (Klein, 1995), and resulted in the removal of many nurses from the senior management positions created following the Salmon Report, (see above) (Owens and Glennerster, 1995), and signalled the importance of 'management' as opposed to administration in the NHS. The need for management and organisation was identified, however leadership did not feature prominently in any formal way, although as noted earlier, leadership was being enacted, even though it was not explicitly acknowledged in policy.

2.3. The Quasi Market 1991–1997

This period saw the establishment of the Internal Market model of purchasers and providers to impose the discipline of the market on health care organisation, and clinical governance to raise quality (DH, 1989, 1997). This was all in the context of what became known as the New Public Management (Ferlie et al., 1996; Hood, 1991) and attention was on the technicalities of the market and the contracting process (Appleby, 2004; Dixon, 1998). In addition the development needs of purchasers, and subsequently commissioners were of concern (Ham, 1994; Mohan, 1996). Although some leadership development was taking place it was not the major project it became in later years.

2.4. Investment and reform: 1997–2008

More recently, drawing heavily on the philosophical precepts of the 'Third Way' (Giddens, 1996), *the NHS Plan* (DH, 2000) signalled further investment in, and development of health care organisation focussed on modernisation (DH, 2001). This was accompanied by the establishment of the National Institute for Health and Clinical Excellence (NICE, 2005), formalising a system of evaluating services based on evidence. The Darzi Review (DH, 2008a,b, 2009a), with its distinct, if not always consistent, emphasis on leadership, referring to it at least 50 times (OT, 2009), and in different ways (Morrell and Hewison, 2013), was a major policy pronouncement on the organisation and management of the English NHS. This document accords great importance to leadership and exhorts all those who work in health care to become leaders. The outcome of this is examined in more detail below.

Imposing distinct start and end points for these periods can never be entirely accurate, because proposals presented as part of a policy package in one year may not be implemented until sometime later, and the effects can take many years to become apparent. In addition, with general

trends in public sector change, such as the New Public Management, it is not always possible to identify the precise origins, trajectory and effect of their component parts (Clarke et al., 1994; Ferlie et al., 1996). Nor is the presentation of this four phase account intended to suggest there was no concern with, or activity in relation to leadership development in the earlier years of the NHS. For example the Leading Empowered Organisations programme was accessed by more than 32,000 nurses and was positively received by many of its participants (Faugier and Woolnough, 2003; Garland, 2003), although it was acknowledged that the initial empowerment of staff would be undone if organisations did not recognise the value of the principles the attendees had explored (Woolnough and Faugier, 2002). Rather, it is a way of summarising a complex mix of circumstances which have culminated in the current preoccupation with leadership in the English NHS. Setting these cautionary comments aside, ordering the approaches to the organisation of the NHS in this way serves to locate the origin of the major thrust for leadership in health policy in the late 1990s. Since then it has been an area of continuing concern. In view of this the next section will review the approaches to leadership development that have been pursued in the NHS, taking 2000 as the starting point.

The review takes the form of a discursive narrative analysis. It is based on the approach developed by McSherry et al. (2012) and informed by Smith (2007) which draws on a wide and sometimes disparate range of theoretical, empirical and policy literature to ensure the diverse sources that have influenced, and reflect the approaches taken to leadership development are addressed.

3. Leadership policy

In stating that 'delivering the plan's radical change programme will require first class leaders at all levels of the service' (DH, 2000, p. 86) and suggesting that these leaders will need to be both clinical and managerial, the *NHS Plan* (DH, 2000) serves as a suitable point of departure for examining the representation of leadership in health care policy. Indeed the *NHS Plan* candidly states: 'Leadership development in the NHS has always been *ad hoc* and incoherent with too few clinicians in leadership roles and too little opportunity for board members to develop leadership skills. That will now change' (DH, 2000, p. 87).

This change was to be brought about by a 'Leadership Centre', established in 2001 as part of the newly formed Modernisation Agency (DH, 2007). A summary report of its work from 2004 (DH, 2004), indicates the scope and scale of its activity. Delivering and coordinating a total of some 47 leadership development programmes or initiatives, the Leadership Centre was central to the realisation of the leadership aspirations outlined in *the NHS Plan* (DH, 2000). These programmes were accessed by more than 68,000 nurses, Allied Health Professionals (AHPs) and Healthcare Scientists (DH, 2004, 2007). This extensive leadership development activity was organised within a broad framework known as *The Leadership Qualities Framework.*

3.1. The Leadership Qualities Framework

The NHS Leadership Qualities Framework (LQF) was developed by the Modernisation Agency as a set of standards for 'outstanding leadership' in the service. It describes the qualities and behaviours expected of existing and aspiring leaders. It was designed to be used across the NHS to underpin leadership development, for individuals, teams and organisations. The NHS Leadership Centre conducted an early implementation programme in 37 health and social care organisations to pilot the framework, which informed the production of a Good Practice Guide to assist other organisations in adopting the LQF (NHS Leadership Centre, 2004). However as Bolden and Gosling (2006) point out, this has a questionable empirical foundation as the initial research it was based on consisted solely of self-report data from a small number of chief executives and directors. The LQF is made up of 15 leadership behaviours which are meant to provide NHS staff with a means of analyzing their leadership roles and responsibilities (NHS Leadership Centre, 2004). These qualities are arranged in three clusters which are: Self-Belief, Setting Direction, and Delivering the Service. *The Good Practice Guide* (NHS Leadership Centre, 2004) includes a brief report of a one year evaluation project commissioned to review the different applications of the LQF in the implementation sites. Presented as short 'case studies', the longest being one full page of text, with most constituting between 6 and 19 lines, they are purely descriptive and there is no indication that they have been subject to the analysis required when case studies are used as a research approach (Yin, 1993, 1994). Consequently the results of this review are somewhat brief and again raise concerns about methodological rigour. The case studies nonetheless reveal a range of applications of the LQF from simply raising awareness, through to providing a structure for leadership development activity, and use in recruitment and selection processes.

Although the framework was presented as allowing for '. . .flexibility and creativity in its application' (NHS Leadership Centre, 2004: 4), it has been characterised by Ford (2005) as an attempt to offer a 'holy grail' solution to the definitional difficulties associated with leadership. Even so, it has become the assumed identity that NHS Managers and professionals should adopt if they are to become successful leaders in the NHS (Ford, 2005). This point will be explored further when reviewing the literature (see below), however it is included here to illustrate how one particular perspective on leadership has been very influential in the policy approach taken to leadership development in the NHS.

The expansion in leadership development activity has continued in the wake of the Darzi Review (DH, 2008a,b, 2009a), which was produced following a year-long consultation process involving more than 62,000 NHS staff, patients, stakeholders and members of the public. It contained plans including: 'Placing a new emphasis on enabling NHS staff to lead and manage the organisations in which they work' (DH, 2008a, p. 13), based on a 'need to further develop clinical and managerial leadership' (DH, 2008a, p. 61). With regard to leadership development, the

recommendation was that a new standard be introduced. This is the *Leadership for Quality Certificate*, which will operate at three levels. Level 1 will be for members of clinical and non-clinical teams with an interest in becoming future leaders. Level 2 will be for leaders of team and service lines, and level 3 will be for senior directors (DH, 2008a, p. 66). This is to be coordinated by the 'NHS Leadership Council' (NLC) a sub-committee of the NHS Management Board with a remit to champion the transformation of leadership across the NHS, however at the time it was not clear how the council would operate (Dawson et al., 2009). Subsequently the Medical Leadership Competencies Framework (NHS III, 2009) was developed, building on the NHS Leadership Competencies Framework. The most recent significant development has been the establishment of the NHS Leadership Academy in July 2012 which seeks to integrate all the national activity supporting leadership development in health and NHS funded services with the principal purpose of developing outstanding leadership in health, focussed on improving patients' experiences and health outcomes (NHS Leadership Academy, 2013a). In pursuit if its mission it has launched what it claims to be the largest and most comprehensive approach to leadership development in the world (NHS Leadership Academy, 2013). This will involve working with a number of international academic institutions and high-performing firms to deliver foundation, mid and senior level leadership programmes (see below) for up to 25,000 NHS staff, including doctors, nurses, Allied Health Professionals, healthcare scientists, and Human Resources and finance personnel, starting September 2013 (NHS Leadership Academy, 2013).

- The foundation level programme is for NHS staff aspiring to a role that involves leading others.
- The mid-level programme is for staff who manage teams and services.
- The senior level programme is for experienced individuals who aspire to executive level roles.

Part of the investment in the academy will be devoted to two programmes specifically for nurses and midwives, both scheduled to start in 2013 (NHS Leadership Academy, 2013).

This summary of leadership development activity in English health care since 2000 demonstrates how leadership has come to be seen as a policy priority. This is reflected in statements such as 'Leadership is vital to realising our ambitions in the plans for the NHS' (DH, 2008c, p. 17) and the organising vision of the NLC: 'World-class leadership talent and leadership development will exist at every level in the health system to ensure high quality care for all' (Dawson et al., 2009, p. 2). Again this is not to suggest that leadership development activity for nursing was non-existent before this period, indeed the Royal College of Nursing Leadership Programme has been running since 1995 and participants have reported that it results in positive change in their leadership capability (Cunningham and Kitson, 2000; Large et al., 2005). Rather it is to indicate that it became a significant policy concern at this time.

Given the widespread change underway in the English NHS (Ham, 2010), it is timely to examine the relevant literature to contribute to the important policy debate concerning how best to approach leadership development in the NHS and nursing, which also has relevance for other health systems. The approach taken in this discussion is to draw on the concept of episteme to inform the analysis.

4. Epistemes of leadership development

Epistemes are implicit rules of formation that govern what constitutes legitimate knowledge (Foucault, 1973, 2002). They are underlying codes that control language, logic, schemas of perception, values and techniques (O'Leary and Chia, 2007). These internalised rules of formation and preconscious processes of inclusion or exclusion give structure to social relations. They are systematically internalised as social conventions (O'Leary and Chia, 2007). Epistemes result in the creation of objects of attention, the fixing of key reference points, and are sense-giving since they embed procedures for interpreting the social world (Foucault, 1973). Although concerned with the rules and conventions for sense-making that take place within broad sociocultural contexts, the focus on epistemes can also direct attention to the policy process and the governance of large complex institutions including the NHS. Our account of the four phases of NHS development, drawing on the work of Mannion et al. (2010) presented earlier, is one chronological account of epistemes, but with more specific reference to leadership, several other such epistemes can be described and examined. This supplements a purely historical analysis of the empirical context for healthcare policy, with a diachronous account of the theoretical context for studying leadership.

4.1. Rationality as the dominant episteme of leadership development

Leadership and leadership development are complex phenomena and a 'one size fits all' policy approach to improving leadership in the NHS seems unrealistic. However, the overall framework for leadership development in the NHS is mainly qualities or competence based. This suggests there is a need for an alternative account to inform policy. The emphasis on competencies as the foundation for leadership development in the NHS is the dominant narrative. We have traced this in terms of (small e) epistemes of policy development, but perhaps it can be explained in terms of an overarching (big E) Episteme, or collective myth: the assumption of rationality in the administration of work and organisations. We draw a distinction between E/episteme in an analogous way to how some differentiate D/discourse or N/narrative. So, the Episteme of rationality is a grand, overarching set of related ideas reflected in the prevailing culture and developed over time. We suggest that smaller, more local epistemes (such as attitudes to leadership development in the NHS) can be seen as nested within this overarching Episteme (though they are not necessarily contained in their entirety or coterminous). Both kinds of episteme

shape expectations about what is possible and imaginable but since we discuss a specific context, it is helpful to signal the difference between a context specific sense and the traditional, Foucauldian sense. Foucault used the term slightly differently over the course of his work, but generally his usage is closer to the grander sense of Episteme, as defining the sensibilities, assumptions and fashions of an age (Foucault, 1973, 2002).

There are many dimensions of rationality, (Albrow, 1990; Brubaker, 1984; Collins, 1994; Eisen, 1978; Ritzer, 2004), and most relevant here is the work of Weber and his concern with the prominence of instrumental rationality. Weber used the term to explain the development of Western society in which actions were quantified in order to inform the organisation of work and the administration of large-scale organisations, which in turn was necessary to underpin the specialised division of labour characteristic of bureaucracy (Jary and Jary, 1991; Weber, 1978).

Instrumental rationality shapes social structures in ways that mean individuals are not left to their own initiative in the search for the best means of attaining a given objective. The influence of the continuing process of rationalisation is most evident in the organisational form of bureaucracies, and a marker of this is a reliance on, and reification of, measurable competencies. Rationalisation emphasises the quantification of as many things as possible and leads to modes of exerting control over people through the replacement of human judgement with disciplinary regimes of rules, regulations and structures (Ritzer, 2004). Ritzer's related account of formal rationality describes the advance of McDonaldization, where society is becoming progressively rationalised and characterised by the predominance of efficiency, calculability, predictability and control (Ritzer, 1998). Although there has been a drive to dismantle bureaucracies in order to create flexible responsive organisations, Hales (2002) found that there has not been a wholesale de-construction of hierarchies and regulations. Where attempts have been made to do this what is left, are not post-bureaucratic, internal network organisations, but 'bureaucracy-lite' organisations, with all the strength of bureaucratic control accompanied by a depleted hierarchy (Hales, 2002). In the case of health care it is evident that rationalisation and bureaucracies are alive and well. For example in an interview based study investigating capital investment appraisal in the NHS, contrary to the rhetoric of debureaucratisation that accompanied the introduction of this process, bureaucracy remained dominant and it was concluded that far from being dead 'King Bureaucracy' was alive and well (Schofield, 2001). This was also found by Ackroyd et al. (2007) who reviewed public management reform in housing, health and social services and concluded that across all three sectors there was evidence of increasing bureaucracy and managerial supervision. Some would regard this as a positive thing, bureaucratic rationality may seem inefficient viewed through the lens of the new public management, yet it might also be seen as crucial to the securing of effective parliamentary democracy and satisfying ethical norms (such as a duty of care for all) (Du Gay, 2000). Notions of rationality and its inherent components of predictability, calculability and standardisation persist and are essential elements in maintaining patient safety (Botwinick et al., 2006; WHO, 2008), the core function of any health system.

Yet in the context of representing leadership, and in devising policy to develop leaders, instrumental rationality may not be universally beneficial, because it closes down representations of leadership as something dialectically complex or (locally) socially constituted. In order to standardise and systematise the process of preparing staff to become leaders, competency based approaches, with their assumptions of predictability, calculability and measurability, seem a ready fit with pre-existing norms associated with the rationality Episteme. This is reflected in the formalised and centralised leadership development systems introduced in the education, government, defence and health sectors (Currie and Lockett, 2007). The Episteme of rationality seems to be at the root of policy in leadership development. Ford (2005) contends that leadership research reflects functionalist roots in theorising on leaders and leadership, assuming that leadership is an indispensible component of all organisations. Through this process of reification the concept of leadership takes on an objective existence, which seems to place it beyond challenge (Ford, 2005). A similar process seems to have occurred in relation to leadership development. Even though the limitations of competency based approaches are widely acknowledged (Bolden, 2004; Burgoyne, 1989; Conger and Ready, 2004), there appears to have been an uncritical acceptance of them as the basis for leadership development in the NHS. This has occurred despite the existence of extensive theoretical accounts which reflect the diversity of leadership.

4.2. Leadership as contested terrain

Grint (2000, pp. 2–3) identifies four broad approaches to representing leadership in the academic literature. He categorises a range of studies in terms of their treatment of the individual and/or the context as 'essentialist'. These levels of categorisation are summarised briefly below. *Trait* approaches place the emphasis on the qualities the individual *has* and what the leader does as a result of this, and take little account of the importance of the context in which leadership takes place (Vera and Crossan, 2004). *Situational* accounts suggest NHS leaders (including nurses) can diagnose situations and determine an appropriate course of action (Hersey and Blanchard, 1988; Vroom and Yetton, 1973), arising from a rational perspective, which assumes leaders possess the necessary information and insight, and have the ability to modify their styles. The dominant situationalist approaches also assume a limited number of ways of describing the context. Whereas *contingency* approaches combine elements of trait and situational accounts, suggesting effectiveness is a matter of fit – the right person for the job (Fiedler, 1967). Finally a *constitutive* approach rejects the objective and static senses of 'an' individual leader and 'a' context as acts of reification and simplification. Instead, it involves acknowledging that these terms are interrelated and mutually constitutive (Fairhurst, 2009). One benefit of a constitutive approach is it allows space to explore how leadership is socially constructed (Collinson, 2005; Grint,

2000, 2005). In sum, when adopting trait approaches, theorists are interested in identifying the characteristics of leaders, which apply regardless of context. Contingency approaches focus on the analysis of the leader's characteristics and the extent to which they match or 'fit' a particular context. Situationalist accounts are built around diagnostic analysis of the context, which then dictates appropriate behaviour. Constitutive accounts reject the idea that the individual and context can be viewed as separate entities or binaries, and instead seek to examine the nature of their interrelationship (Fairhurst, 2001). It could be regarded as surprising then that the current leadership framework, albeit broader in scope than many of its predecessors, continues to place great emphasis on personal qualities and competencies (NHS Leadership Academy, 2011), perhaps reflecting their dominance, and suggesting the need for further discussion of different perspectives.

4.3. The evidence

The need for a different perspective in the form of a counter narrative is confirmed by work that was commissioned by the NHS Leadership Centre. The 15 reports produced were reviewed by the Office for Public Management in 2004 (OPM, 2004), and the findings included the conclusion that leadership development in the NHS was underpinned by a traditional view of leadership as an individual skill resulting in an emphasis on developing individual skills and abilities (Hartley and Hinksman, 2003). It was recommended that an approach incorporating a concept of leadership as a complex interaction between the leader, the organisation, and the social context would be more suitable as it reflects the nature of leadership as a social process. Furthermore although their use is widespread, competency approaches were found to be limited, because of their individualistic focus. It was concluded that the problem of an overemphasis on competencies could be resolved if there was a shift to consideration of team competencies. Though this lends support to the idea that an emphasis solely on individuals is simplistic, this could of course simply displace or reformulate the problem, and promote a solution based on a modification of competency frameworks (Hartley and Hinksman, 2003). There is support for this approach though, as Williams (2004) found leadership was more effective when it focused on the team rather than the individual and addressed the connection between leadership and change.

More promisingly perhaps, in terms of signalling a break from competency frameworks another study in this programme concluded that there is no 'one best way' to lead, or one ideal set of competencies for a leader. Instead, Buchanan suggested that leadership development in the NHS may need to embrace the notion of dispersed leadership (Buchanan, 2003). Buchanan argued that the NHS should 'exploit the full range of leadership perspectives, offering a toolkit of techniques and ideas, rather than being wedded to a single, narrow and possibly outdated view' (Buchanan, 2003, p. 16). These studies identify the limitations of relying on competency based approaches to development.

In view of this it is interesting to note that the Leadership Framework (NHS Leadership Academy, 2011), which incorporates the model of the Medical Leadership Competencies Framework (NHS III, 2009) and the Leadership Qualities Framework (NHS III, 2009a), relies on an approach which has been subject to considerable critique. It is consistent with the dominant episteme summarised earlier and has been questioned by Bolden et al. (2006) who have identified the limitations of NHS Leadership Qualities Framework, as *reductionist* (fragmenting the role of leader rather than representing it as an integrated whole); based on *generic competencies* (that assume a common set of capabilities irrespective of the leadership situation); and an approach that *reinforces traditional ways of thinking about leadership* (rather than challenging them). The framework focuses on measurable behaviours and outcomes, to the exclusion of more subtle, and perhaps more important qualities such as interactions and situational factors, encouraging a mechanistic approach to education which results in 'training' of leaders to improve job performance, rather than education to develop wider cognitive abilities (Bolden et al., 2006).

Bolden et al. (2006) argue that leadership frameworks such as the NHS Leadership Qualities Framework are too conceptually and methodologically flawed to be of much benefit on their own. Indeed, they go on to suggest that the longer this model is used, the greater the likelihood of it eroding the very thing that the NHS is trying to nurture – a culture of responsible shared leadership. This reflects the unease in certain theoretical accounts of leadership, for instance Collinson (2005) observes that leadership can be thought of as a set of dialectical relations. These include those existing between: leaders/followers; control/resistance; dissent/consent; and men/women. For example in the leader–follower dynamic there is always the potential for conflict and dissent. Yet this is not reflected in what he terms 'orthodox' studies which present an uncontested notion of leadership (Collinson, 2005). It could be argued that this has been carried through into the competency approaches which rest on a presumption of leadership as a 'given' and unquestionable as a force for good. Collinson also highlights the gendered nature of the ambiguous and contradictory relations between leader–follower, power–resistance, and consent–dissent. This is a line of analysis which is pursued by Ford (2005) as well who suggests leadership is achieved through a range of exclusionary practices, with one being the failure to consider the androcentric (male dominated) nature of organisational life, a particular concern for nursing.

It is unrealistic to expect competency approaches to engage directly with such complex issues, and so there remains a significant challenge to show how these multiple dialectics interrelate and are mutually constitutive (Collinson, 2005). The popular and officially sanctioned notion that leadership at all levels of the NHS is a politically desirable and legitimate goal could usefully be subject to sustained critical scrutiny rather than merely assumed (Learmonth, 2003). As Learmonth argues, the personality qualities that 'good' leaders are deemed to posses, such as self-confidence, and enthusiasm are not objective categorisations. Rather they are terms of moral

and political approval that are meaningless when abstracted from a particular context. This again underlines the need for a counter narrative.

5. A counter narrative

For the last decade, policy making in England has ostensibly been founded on the principle of 'What matters is what works' (Cabinet Office, 1999). However in a study based on interviews with 42 policy makers in a range of middle management and senior civil service positions Campbell et al. (2007) found that the reality of policy making was messy and unpredictable. Evidence was regarded as just one factor to be taken into account along with political imperatives, media coverage and world events. Similarly Lavis et al. (2005) found that systematic reviews were never cited as the source when research evidence was used by health care managers and policy makers. The difficulties experienced by policy makers in using evidence include accessibility, usability and competing sources of influence (Jewell and Bero, 2008). In order to address these problems Sanderson (2002) advocates that researchers should understand the context of policy making and do more to relate their work to this context, and consider pressing policy concerns and challenges. The development of a counter narrative of leadership development is one means of doing this.

The role stories and language play in representing phenomena, not simply in communication but as a resource, is of wide interest in the study of organisations (Alvesson and Karreman, 2000; Alvesson and Sveningsson, 2003; Oswick et al., 2000). It is also relevant in particular areas of practice such as innovation and diffusion of new practices (Abrahamson and Fairchild, 1999; Clark, 2004; Giroux, 2006; Green et al., 2009; Green, 2004), in establishing legitimacy (Benjamin and Goclaw, 2005; Chreim, 2005; Mueller and Carter, 2005), and as a frame of reference for interpreting complexity (Barry and Elmes, 1997; Boje, 1991). In this case we suggest that a particular orthodoxy has developed in relation to leadership development – an episteme based on 'competency' approaches that is nested in a grander or broader episteme of rationality. The prevalence of this episteme in policy is important because it closes off other accounts and drives policy in a particular direction. In developing a counter narrative, we try to direct attention to the role that the stories we tell ourselves, and others, play in sense-making (Grint, 2007; Weick, 1995). In terms of the relationship between policy development and policy implementation, narrative is critical since the way in which policy makers represent events surrounding reform and leadership also shapes the thinking and practice of leaders in health care and nursing.

Barry and Elmes define narratives as, 'thematic, sequenced accounts that convey meaning from implied author to implied reader' (Barry and Elmes, 1997, p. 431). In this sense, the competency approach can be understood as the outcome of a narrative reflecting a specific model of leadership. This is central to the work of bodies such as the NHS Leadership Council and the Modernisation Agency, and has contributed to the emergence of a particular approach to leadership development. Barry and Elmes (1997) argue that across different genres, two things make a narrative effective. First, it must establish credibility. Second it must create a sense of the unfamiliar or novel. These two conditions can inform the development of a counter narrative to widen the debate about leadership development in the NHS. First there is a considerable body of literature which presents a credible challenge to competency approaches; second escaping from the repetitive refrain of competencies through greater consideration of reflection, discussion and experience (Bolden et al., 2006), is reliant on the involvement of policy makers. If presented in the right way our analysis may influence policy makers to look beyond seeking to control and regulate individuals' identities within organisations, and consider an alternative to wishing for conformity with specific competencies' (Ford et al., 2008, p. 79).

One simple way of relating this counter narrative is provided by Rodgers et al. (2003). In an extensive international study they found that accompanying the competency movement is an attendant risk of reverting to a checklist approach to development. Although the checklist approach may be an attractive and superficially rational way of imposing order on the complex task of leadership, it operates from an empirically contested and largely unproven base. Over-reliance on such an approach constrains and undermines meaningful, pertinent, innovative and potentially more effective leadership practice (Rodgers et al., 2003). In response to this they developed a framework made up of four quadrants identifying broad approaches to leadership development: Prescribed and individual; Emergent and Individual; Prescribed and Collective; Emergent and Collective.

Most leadership development activities can be located in the first quadrant, in that they are designed for individuals and tightly specified in terms of content and outcomes. And, almost all leadership development activities are focused on individuals – placing them in either quadrant one or two. This suggests that to emphasise collective approaches could advance the debate on policy development. One of their recommendations was that researchers should consider applying this framework when considering how leadership and leadership development are constructed and evaluated. We suggest it is possible to use this framework as a way of summarising and organising the more complex suggestions we have made in our analysis. The Rodgers et al. (2003) framework can be a starting point to explore how assumptions about leadership in policy reflect an episteme of leadership as an individual, competency based phenomenon, located within an overarching Episteme of rationality. The framework very simply identifies the limitations of competency accounts (and consequently contingency and situationalist accounts), and the absence of a constitutive approach. It can also be used to acknowledge the various dialectical complexities that characterise leadership as an activity, and consider leadership development as something that is sometimes irreducibly complex or a local, context-bound phenomenon (rather than one that is susceptible to standardisation).

There is a danger perhaps that, apart from having the virtue of being simple, the Rodgers et al. (2003) framework is somewhat simplistic. For instance, in the broader theoretical context of the Foucauldian notion of epistemes, the depiction of four quadrants unhelpfully implies sharper boundaries than is consistent with a complex, variegated and historically contingent account of leadership development. Nonetheless some simplification is inevitable when trying to summarise, and this is offered as a practical means of highlighting alternative approaches to the dominant policy narrative of competency based approaches to leadership development, in an accessible and straightforward way. Roe (1994) suggests that many public policy issues have become so uncertain, complex and polarised-that their empirical, political, legal and bureaucratic merits are unknown, or not agreed upon. This complexity, uncertainty and politicisation can result in a sense of analytical helplessness or frustration, where the only things left to examine are the different stories policy makers and their critics use to articulate and make sense of that uncertainty, complexity, and polarisation (Roe, 1994, p. 3). Though recognizing the concerns identified by Roe, we argue for using Rodgers et al.'s (2003) framework not only to analyse the various stories of leadership development in the NHS, but also to contribute to the development of a counter-narrative. This can challenge the assumptions of rationality that underpin the competency based perspective on leader development, and re-present policy problems relating to leadership in the NHS by a comparison and organisation of various potential accounts of leader development.

The formulation of effective policy involves the analysis and interpretation of a range of quantitative and qualitative data and other information (Smee, 2005), however even when good quality, relevant research evidence is available, other features of the policy making process can prevent the development of evidence-informed policy (Jewell and Bero, 2008). In view of this, the importance of the counter narrative presented here becomes clearer. The evidence concerning the limitations of competency based approaches has not influenced policy in this area, quite the contrary. We suggest that this is because policy making is not simply about applying objective evidence to solve problems that are out there waiting for solutions, it is about how those problems are constructed (Greenhalgh and Russell, 2009). In challenging some of the assumptions of what we call the rationality Episteme, this counter narrative offers an alternative and more nuanced way of framing the problem of how to develop leadership in the NHS.

6. Discussion

The importance of leadership for nursing and patient care is of international concern (Bishop, 2009; Freshwater et al., 2009), consequently developing the right policy to ensure leadership development improves the quality of nursing leadership is vital. The evidence suggests that competency based approaches alone will not achieve this. For example in a recent systematic review it was found that leadership focused solely on tasks is not sufficient and if the optimum outcomes for nursing are to be achieved then transformational and relational leadership are needed (Cummings et al., 2010). This was also evident in the work of Nielson et al. (2008) in elderly care in Denmark where it was demonstrated that a transformational leadership style improved staff well-being. It can also have a positive influence on the retention of nursing staff (Cowden et al., 2011), and the learning of nursing students (Walker et al., 2011), although Hutchinson and Jackson (2013) have questioned the validity of the model arguing it places too much emphasis on charisma and 'heroic' leadership; neglects 'dark' or avoidant leader behaviours; and does not give sufficient attention to the importance of gender and culture. However such alternative accounts at least extend the debate from the confines of the competency episteme. Similarly in a meta-synthesis of qualitative studies, Pearson et al. (2007) concluded that leaders who have emotional intelligence are more likely to have a positive impact on staff, patient, and organisational outcomes. Emotional intelligence involves being able to motivate, communicate effectively including the ability to listen-and being honest, which needs to be fostered in an appropriately supportive environment (Pearson et al., 2007). This in turn can have a positive influence on future leaders as structural empowerment, as enacted by nurse managers, can help develop clinical leadership skills in staff nurses (Patrick et al., 2011). Transformational Leadership and Emotional intelligence are vast topics in their own right (see for example Avolio et al., 1999; Bass and Riggio, 2006; Ergeneli et al., 2007; Freshwater and Stickley, 2004; Kark, 2004; McQueen, 2004; Smith et al., 2009), moreover several other interpretations exist, in addition to those examined earlier, including distributed leadership (Bolden, 2011; Currie and Lockett, 2011), servant leadership (Greenleaf, 1991, 1996), and Action Centred Leadership (Adair, 1989). They are referred to briefly here to signal the vast array of approaches to leadership that have been explored, yet are largely absent from the policy narrative. Although competency based development approaches can help nurses develop some of the abilities inherent in these other theorizations of leadership, unless the organisational structures are in place to support a range of approaches it is unlikely that the dominance of competences will be challenged. This is borne out by findings which indicate that when leading change the importance of relationships comes to the fore, because by leading relationships, processes and culture nurse leaders create the prerequisites for good patient care, which is achieved through a combination of processes (Salmela et al., 2012). Salmela et al. (2012) developed a 'three dimensional' model of leadership which reflects its complexity and belies the suitability of competencies as a means of accurately conveying the nature of leadership in nursing. The need for nurse leadership to be empowering was also identified in a large Canadian survey based study which demonstrated that unit level leadership affects outcomes, and that empowering leadership creates positive work climates (Laschinger et al., 2011). This approach has wider applications as it has been found to improve patient safety in a developing country (Stewart and Usher, 2010). This evidence all suggests that leadership development is

worthwhile and necessary, however imposing a 'one size fits all' competency model of learning is not appropriate.

7. Conclusion

Competencies have a place as part of an overall approach to leadership development, however privileging them above all other perspectives of such a relationally complex activity as leadership undermines the considerable efforts being made to support health care workers in their leadership roles. It has been argued that the ubiquity of 'competency' in current mainstream dialogue serves to restrain leadership thinking and development, rather than facilitating examination of its richness, texture, and possibility (Carroll et al., 2008). If leadership is to advance further in healthcare then the debate needs to include a wider range of perspectives and approaches.

The purpose of this paper was to challenge the dominant narrative of leadership development being a process that is best understood and addressed in terms of specific individual qualities and competencies and highlight the importance of context and relationships. Given that there is a substantive case to support such a challenge, it seems an alternative approach is needed to enliven the debate. Recognising that policy making often occurs without recourse to the evidence, the device of contrasting epistemes has been suggested. Seemingly incommensurable epistemes can be used constructively to contrast the different underlying logics of justification shaping perceptions, sense making and decision making in organisations (O'Leary and Chia, 2007). In comparing and contrasting the logic of competency based leadership development approaches, with the wealth of material that highlights its deficits, we hope to have shown how a counter narrative is possible and can contribute to extending the debate about leadership development policy in the NHS, in nursing, and more widely.

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