

Talent Management in the NHS Managerial Workforce

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Glossary of terms/abbreviations

ALB	Arms Length Bodies
ALS	Action Learning Sets
BME	Black and Minority Ethnic
CEO	Chief Executive Officers
CfWI	Centre for Workforce Intelligence
CIPD	Chartered Institute of Personnel Development
COSOP	Staff Transfers in the Public Sector Statement of Practice
CPD	Continuing Professional Development
DH	Department of Health
DHSS	Department of Health & Social Security
DoF	Director of Finance
FOI	Freedom of Information
GMTS	Graduate Management Training Scheme
HCM	High Commitment Management
HEE	Health Education England
HPT	High Performing Trusts
HPWS	High Performance Work Systems
HR	Human Resources
HRM	Human Resource Management
HSMC	Health Services Management Centre
IHSM	Institute of Health Services Management
KF	Key Findings
LD	Leadership Development
MA	Modernisation Agency
MARS	Mutually Agreed Resignation Scheme
mt	managing talent
MTS	Management Training Scheme
NHS	National Health Service
NHS IMAS	NHS Interim Management and Support

NHSIII	NHS Institute for Innovation and Improvement
NHSTA	NHS Training Authority
NLC	National Leadership Council
NSCA&C	National Staff Committee for Administrative and Clerical Staff
PCT	Primary Care Trust
PDP	Personal Development Plans
R&D	Research & Development
ROI	Return On Investment
RSO	Regional Staffing Officers
SCMET	Standing Committee management Education and Training
SFC	Spoilt for Choice
SHA	Strategic Health Authority
T&LP	Talent and Leadership Plans
TLP	Top Leaders Programme
TM	Talent Management
UK	United Kingdom
US	United States
WRT	Workforce Review Team
SM	Senior Managers

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Executive Summary

Background

In 2004 the National Health Service (NHS) introduced 'Talent Management' (TM). This approach developed in the 1990s, initially in the private sector in the USA. However, it has been claimed that the TM literature '*reveals a disturbing lack of clarity regarding the definition, scope and overall goals of talent management*'⁽¹⁾. A working definition of TM as given by the Chartered Institute of Personnel Development (CIPD)⁽²⁾ involves:

'... the systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation.'

The most frequent TM practices include: in house development programmes; coaching; succession planning; mentoring and buddying; graduate development programmes; courses at external institutions; internal secondments; assignment centres; 360-degree review; job rotation and shadowing; development centres; MBAs; action learning sets; and external secondments.

It is clear that the NHS had carried out much of this activity before 2004, in an approach that we term 'mt' (managing talent). However, a systematic TM policy may contribute to addressing three of the main leadership problems of the NHS: recruiting and retaining Chief Executives; a more diverse or inclusive leadership or an 'NHS of all the talents'; and benefits in terms of organisational performance, as organisations can achieve competitive advantage through people.

Aims

The main aims of the study are 1-3, while the secondary aims are 4-5.

1. To explore and document the mt/TM approaches that assisted the career trajectories of four cohorts of managers/administrators from 1970s to 2000s
2. To examine the facilitators and barriers to talented individuals achieving their potential
3. To evaluate the impact of different Talent Management (TM) and earlier 'managing talent' (mt) schemes on individuals

4. To explore how values, motivations and beliefs link with managerial careers
5. To examine how TM links with organisational success

Methods

The research design is a mixed method quantitative (questionnaire) and qualitative (interview, focus Group) examination of how four different cohorts of managers navigate the multiple routes through their careers. It consists of a quasi-probability element that focuses on a maximum variety sample and a purposive element that seeks policy views at central and Strategic Health Authority (SHA) level, and examines TM in high performing NHS organisations. The research was conducted in six separate stages:

1. Literature review
2. A focus group of managers to validate findings of previous research and from the literature review, and to pilot our interview schedule and questionnaire survey
3. Qualitative interviews with those responsible for TM at national and SHA levels
4. Qualitative interviews with four cohorts of managers from a variety of socio-demographic and education backgrounds in a variety of roles in different organisations.
5. Questionnaire Survey focusing on basic career histories and experiences of TM and mt.
6. Exploration of NHS Staff Survey and qualitative (interview) examination of TM in five high performing organisations.

Results

According to the literature review, definitions and scope of TM were often unclear and contested, and there is little robust evidence that TM contributes to organisational performance. Moreover, much of the work on TM focuses on the USA and the private sector, and there is very limited work on the UK in general and the public sector and the NHS in particular.

Some themes emerged strongly from a variety of data sources. First, there was considerable discussion about whether the NHS should have a TM system and, if so, what form it should take. It was broadly agreed that the TM system was 'long overdue' and was an improvement on the more informal, variable and ad hoc system that it replaced. However, many respondents considered that the previous system cast a long shadow in that

the new system could perpetuate, and even legitimate, the 'old boys network'. Similarly, while one of the main aims of the new system is to increase diverse leadership in the NHS, some considered that it had the potential to be ageist, sexist and racist.

There was no clear agreement on the appropriate system architecture. Some respondents considered that the private sector provided a suitable TM model, but others regarded the NHS as a collection of competing organisations rather than a collaborative system. This was associated with a clear conflict of views over whether 'talent' was the property of the system (to be shared) or the organisation (to be "hoarded"). Most respondents considered that the NHS should adopt a more "inclusive" approach to talent (where development should be cascaded throughout the workforce) rather than the "exclusive" approach in some private sector organisations where TM is restricted to "high flyers", "A-players" and succession planning. Moreover, many felt that public service organisations had a duty to lead the way in terms of equality and diversity.

Turning from the system architecture towards the components of the system, the main facilitators that enabled staff to pursue development opportunities were self-motivation, support from line manager and senior managers and directions from Personal Development Plans (PDPs) arising from appraisals. The findings on barriers from the different data sources were less consistent. There was little discussion of barriers in the qualitative interviews, but over a third reported barriers in the quantitative survey (although these may not have been severe). However, there was some consistency in the nature of the barriers. The main barriers to accessing development were seen as lack of organisational support and lack of funding. Once on the course, the main barrier was seen as lack of dedicated study time, leading to people trying to juggle work, study and home commitments. There was also some consistency in that more female and Black and Minority Ethnic (BME) staff tended to report barriers, which were perceived as very severe in a few cases.

The development courses that were attended were broadly positively regarded in terms of content, but there was less consensus on the benefits for the individual and the organisation. The links between TM and organisational performance are rather tentative, but possible factors include development being seen as important in the organisation, with clinical leadership and PDPs arising from the appraisal process being taken seriously, and there appeared to be a more inclusive approach to TM. Finally, given the financial climate, reorganisation, and threats of redundancy for some, it was not clear who would be responsible for carrying

forward the TM initiative, and there were great concerns over the future of managerial careers in the NHS.

Conclusions

The evidence base for TM remains rather unclear, especially for the contexts of the UK and public service. Moreover, the future of TM is unclear in the current financial and organisational climate. Nevertheless, it does appear that a clear and systematic approach to TM can yield individual and organisational advantages.

Recommendations

- (i) Identify who will take responsibility for TM in the future.
- (ii) Take a more inclusive approach to TM.
- (iii) Awareness of the TM system needs to be increased throughout staff in the NHS.
- (iv) Quantitative and qualitative improvements are required in the appraisal/ PDP system as this appears to be an important foundation for a TM system.
- (v) Supply and demand, 'spoilt for choice' (SFC), figures need to be refined. On the one hand, the demand figures may be too high ($N+2$ appears more accurate than $N*3$). On the other hand, the figures for talent pools may be too high.
- (vi) Continue the stress on clinical leadership, but clearer guidance is required on aspirations on the proportion of clinicians and doctors in senior management.
- (vii) Continue the stress on increasing the diversity of leadership, but clearer guidance is required on whether aspirations should reflect workforce or population, and – in line with the Equality Act 2010- greater stress should be placed on other dimensions such as disability.
- (viii) Broaden the activities that constitute TM to place greater stress on wider development activities including coaching, mentoring, formal/informal study programmes, job rotation
- (ix) More stress on developing joined up systems to plan, record, and track talent is required

Suggestions for further research

- i. a cost/benefit evaluation for development activities (rather than just courses) beyond 'Kirkpatrick level 1': for example, should more investment go to Action Learning Sets (ALS) rather than formal courses?
- ii. an exploration of the effects of reorganisation on talent and diverse leadership
- iii. an exploration of how appraisal/PDP links to organisational performance
- iv. a realistic/ contextual evaluation of TM
- v. an evaluation of different approaches to TM (e.g. Academies) given future likely differentiation (natural laboratory).

The Report

1 : Introduction

1.1 Introduction

It is generally claimed that an explicit focus on 'talent' and 'talent management' (TM) developed in the 1990s, and is usually associated with a book by McKinsey consultants entitled 'The War for Talent'⁽³⁾. According to Chartered Institute of Personnel Development⁽⁴⁾ (CIPD) since McKinsey first coined the expression 'the war for talent', the term talent management has become increasingly common in the world of 'human resources' (HR). TM has received a remarkable degree of practitioner and academic interest.⁽⁵⁾ A casual review of the trade and popular literature on the topic would certainly lead one to conclude it is a popular and growing field. A search on the phrase "talent management hr" in late 2004 using a popular internet search engine yielded over 2,700,000 hits, and over 8 million hits one year later⁽¹⁾ (p139). A search in September 2011 gave about 15.6 million hits.

Lewis and Heckman⁽¹⁾ continue that given the number of consulting firms engaging in talent management and the growing number of articles and books on the topic, one might also believe TM to be a well-defined area of practice supported by extensive research and a core set of principles. However:

'...we find that such is not the case. A review of the literature focused on talent management reveals a disturbing lack of clarity regarding the definition, scope and overall goals of talent management'. (p. 139)

Collings and Mellahi⁽⁵⁾ agree that a cursory review of the talent management literature reveals a degree of debate as to the conceptual boundaries of the topic, while Aston and Morton⁽⁶⁾ noted that there isn't a single consistent or concise definition of TM (p. 30).

Ford et al⁽⁷⁾ write that there is a vast outpouring of web- and paper-based discussions on the topic by management consultants, but as yet scientific studies of its effectiveness are almost non-existent. The academic publications that do exist tend to adopt an unquestioning and uncritical stance, are rarely research-based and, with rare exceptions, are as concerned as management consultants with propounding one best way to do talent management. There is therefore little credible research into talent

management. What research has been carried out comes from descriptive case studies, some of which provide little detail and thus make external evaluation difficult. The available evidence, based on a very thin evidence-base, suggests that there is little consensus about what talent management actually is, and that organisations define and practise talent management in many different, often conflicting ways.

Lewis and Heckman⁽¹⁾ found that the literature can best be described in terms of three research streams:

1. talent management is conceptualized in terms of typical human resource department practices and functions;
2. talent management is defined in terms of HR planning and projecting employee/staffing needs; and
3. talent management is treated as a generic entity and either focuses on high performing and high potential talent or on talent in general.

This third type appears to enjoy the highest profile with the focus of Michaels et al⁽³⁾ on 'A players', Smart⁽⁸⁾ on 'topgrading' and Collins⁽⁹⁾ advice to 'get the right people on the bus'

Unclear definitions have not prevented the development of a number of sub fields such as strategic TM⁽⁵⁾ and global TM⁽¹⁰⁾, but attention to genus before more clearly defining species appears premature. Moreover, TM has already come under some heavy fire. Gladwell⁽¹¹⁾ writes of the 'talent myth'. He argues that the McKinsey 'talent mind set' of A players made Enron the 'ultimate talent company', and asks if Enron failed not in spite of its talent mind set, but because of it. He concludes that the talent myth assumes that people make organisations smart, but more often than not, it's the other way around.

Similarly, Pfeffer and Sutton⁽¹²⁾ criticise the focus of 'The War for Talent' on A players, and its 'rule of crappy people'- bad managers hire very, very bad employees (Chapter 2 & 4). They argue that an obsession with individual 'talent' can be hazardous to organizational health. It is not easy to identify talent, talent is not fixed, and great systems are often more important than great people- the law of crappy systems trumps the law of crappy people. They point out that the 'War for Talent' collects information on the independent variable- practices for managing talent- after the time period covered by the data on the performance that TM presumably causes (p. 36) and if the authors' temporal logic were applied to research on the link between smoking and lung cancer, the conclusion would be that lung cancer causes smoking (p. 241, FN).

1.2 TM in the United Kingdom

CIPD⁽⁴⁾ report on a survey of over 600 responses that examine current attitudes and practices in relation to talent management and development within United Kingdom (UK) organisations. Its key findings include:

- Fifty-one per cent of respondents undertake talent management activities, although only 20% report having a formal definition for it.
- Developing high-potential individuals (67%) and growing future senior managers (62%) are the two main objectives for talent management activities.
- In-house development programmes, coaching and succession planning are the most common activities.
- The most effective practices are in-house development programmes; internal secondments; and coaching. Succession planning, external secondments and action learning are considered to be the least effective.
- Ninety-four per cent agree that well-designed talent management development activities can have a positive impact on an organisation's bottom line.
- Forty-seven per cent agree there is currently a shortage of high-quality talent in UK organisations.
- TM is more common in the private (56%) than public (46%) or voluntary (30%) sectors, and in larger (61% for over 500 employees) than smaller (35% for less than 249 employees) organisations.
- Organisations are tending to focus on their 'high potential' employees (40%) than for all their staff (28%)

The most frequent TM practices are (in order): in house development programmes; coaching; succession planning; mentoring and buddying; cross-functional project assignments; high potential development schemes; graduate development programmes; courses at external institutions; internal secondments; assignment centres; 360-degree review; job rotation and shadowing; development centres; MBAs; action learning sets; external secondments.

However, CIPD⁽⁴⁾ claim that the survey reveals that the most widespread methods are not always the most effective. In-house development programmes are the exception, being used frequently and also considered to be highly effective (95%). This Succession planning, for instance, is the third most frequently used talent management activity, but is considered the least effective of all the practices. The most effective practices are believed to be in-house development programmes, internal secondments

and coaching, while succession planning, external secondments and action learning are considered to be the least effective.

Looking at activities as a whole, 65% of respondents rate their organisation's talent management activities as 'very effective' or 'effective'. The vast majority of the sample agree that talent management is a business priority for their organisations (87%), while 94% of respondents agree that it can have a positive impact on an organisation's bottom line. However, less than a third of respondents (29%) agree that activities should be focused on high-flyers or high-potential employees, and two-thirds agree that using the term 'talent' can be demotivating for employees not selected to take part. This more inclusive perspective on talent management is further supported by the 52% who also agree that special attention needs to be paid to identifying and managing talent within certain groups of workers such as women, ethnic minorities and older workers. Some of the barriers to talent management reported by survey respondents include a lack of resources (money and time), poor management buy-in, and a lack of a formal, cohesive strategy.

1.3 TM in the National Health Service

Recent years have stressed the importance of management^{(13); (14); (15)} and leadership within the National Health Service (NHS)^{(16); (17)}. The importance of workforce planning^{(18); (19); (20); (21)} and more recently Talent Management^{(22); (23)} has also been recognised, and stressed by individuals such as the Chief Executive (CE) of the NHS, David Nicholson, and the NHS Workforce Director General, Clare Chapman.

In 2004 the NHS adopted a new approach to identifying and developing managers with the establishment of a national talent management team whose aim is to 'identify and position high potential individuals to have a disproportionately positive impact on the organisational performance'⁽²⁴⁾. However, it is important to note that while 'Talent Management' (TM) may be new, the NHS has long been concerned to manage talent (mt). For example the Management Training Scheme (MTS, previously known as the Graduate Training Scheme) is now 50 years old⁽²⁵⁾ and one of the aims in Stewart et al's study of the District Administrator was to help to identify more clearly the training requirements for the post⁽²⁶⁾. In short, Blass⁽²²⁾ argues that every organisation has a talent management system whether it recognises it or not', and so we argue that it is necessary to examine long-standing 'mt' initiatives before 'TM' (p. 3).

A systematic TM policy may contribute to addressing three of the main leadership problems of the NHS. First, a good TM policy should reduce the

problems of the NHS in recruiting and retaining Chief Executives. Hoggett Bowers⁽²⁷⁾ found that the length of tenure of NHS acute Trust Chief Executive Officers (CEOs) was, on average, 2 years 4 months in 2002. With the claim of David Nicholson that 'We find it very difficult to recruit people who want to be chief executives - the average time they spend in post is just 700 days.'⁽²⁸⁾, they repeated and extended this work. The survey, with a response rate of fifty-seven percent of NHS organisations, found that just over fifty percent of NHS CEOs and Directors of Finance (DoF) had been in their post for less than two years, whilst just over ten percent had been in post for over seven years. After two years, just over twenty five percent of CEOs and forty percent of DoFs would have left their post. By the end of year four, around forty percent of both CEOs and DoFs would still be in the same post and sixty percent would have moved on. Of those who left, twenty five percent were promoted. By that we mean they went onto be CEOs or DoFs in larger or more complex NHS organisations. Almost thirty percent left their post through Trust mergers or Primary Care Trust (PCT) "re-organisation", just under ten percent left to join other sectors, and around ten percent moved into less senior roles in the NHS. Only five percent retired at their full pension-able age. Few were "sacked", although in the category of "leaving with a package," there may have been individual or organisational performance issues (either actual or perceived). About twenty five percent of senior executives had a leaving package, including those covered by a compromise agreement, those taking early retirement and those taking ill health retirement. A number of anecdotal comments has suggested that CEO turnover in the NHS is rising. By contrast, surveys from the private health sector have shown that the time spent by CEOs in the private health sector has fallen over the last ten years. More than half of CEOs in the private health sector plan their departure. Around a quarter leave an organisation because a merger or acquisition has taken place and a quarter leave office because of performance or "political issues". The time spent by executives in CEO roles in the private health sector averages seven years. In contrast, it has been claimed that NHS CEs have a shorter shelf life than Premiership Football Managers⁽²⁷⁾ or Second World War spitfire pilots.⁽²⁹⁾

Second, it is claimed that it will contribute towards a more diverse or inclusive leadership or an 'NHS of all the talents'. It is broadly accepted that NHS senior management does not reflect either the workforce or the community it serves, and that urgent action is required to address this^{(30); (31); (32)}. Similar to the point above, it has been claimed that there is a 'business case' for diversity^{(33); (34)}. For example, Cox and Blake⁽³³⁾ the areas of competitive advantage include: (1) cost, (2) resource acquisition, (3) marketing, (4) creativity, (5) problem-solving, and (6) organizational flexibility. According to NHS Employers⁽³⁵⁾, with demographic pressures such as an ageing workforce and increasing recognition that a diverse workforce needs to be part of the core business of the NHS, talent management can

also be seen as a chance to recruit, identify and develop talent from as wide a pool as possible. Diversity can be considered not only in terms of age, gender, ethnicity, sexuality, religion and belief and human rights, but also in terms of experience and different ideas and approaches. With the Equality Act of 2010, there will be more emphasis on recruiting and developing an NHS workforce that reflects the patients it serves. No talent management strategy should neglect this.

Third, it is claimed that there are benefits in terms of organisational performance. This is related to the wider literature on 'high commitment management' (HCM) and 'high performance work systems' (HPWS) which claims that organisations can achieve competitive advantage through people^{(36); (37); (38); (39); (40); (41); (42)}. However, there is much less material on the links between TM and organisational performance. According to NHS Employers⁽³⁵⁾, talent management is essentially making sure you have the right person in the right place at the right time. It can be defined as attracting and integrating highly skilled workers and developing and retaining existing workers. It claims that the benefits in terms of organisational performance are now beyond dispute. Good leadership and talent management systems can help organisations perform 10 to 20 per cent better than those without them. Companies with stronger leadership development have up to 7 per cent higher profits than competitors. 85 per cent of the 20 top performing companies hold their leaders accountable for developing talent.

Research by McKinsey & Co⁽⁴³⁾ suggests there are significant skills and knowledge deficits in middle and senior management compared with their counterparts in industry and private healthcare. The study, based on an assessment of 126 NHS and other hospitals across the UK, suggests that improved operational effectiveness, performance management and talent management are associated with a number of success criteria, including lower infection rates, lower readmission rates, more satisfied patients, more productive staff and better financial margins. They found a considerable gap between the average management-practice scores of the NHS hospitals and the average scores in their research into UK industrial companies. There was also a large gap between the management scores of NHS hospitals and those of private hospitals. According to McKinsey⁽⁴⁴⁾, management practices in three broad areas (operations, performance, and talent) are strongly related to health outcomes (30 day adjusted acute myocardial infarction mortality rate) in seven countries (including UK).

1.4 Aims and Objectives

The main aims of the study are 1-3, while the secondary aims are 4-5:

1. To explore and document the mt/TM approaches that assisted the career trajectories of four cohorts of managers/administrators from 1970s to 2000s
2. To examine the facilitators and barriers to talented individuals achieving their potential
3. To evaluate the impact of different Talent Management (TM) and earlier 'managing talent' (mt) schemes on individuals
4. To explore how values, motivations and beliefs link with managerial careers
5. To examine how TM links with organisational success

1.5 Research Design

The research design is a mixed method quantitative (questionnaire) and qualitative (interview, Focus Group) examination of how four different cohorts of managers navigate the multiple routes through their careers. It consists of a quasi-probability element that focuses on a maximum variety sample and a purposive element that seeks policy views at central and Strategic Health Authority (SHA) level, and examines TM in high performing NHS organisations.

1.6 Methods

The research will be conducted in six separate stages, as follows:

Stage 1: Literature review

Stage 2: A focus group of managers to validate findings of previous research and from the literature review, and to pilot our interview schedule and questionnaire survey

Stage 3: Qualitative interviews with those responsible for TM at national and SHA levels

Stage 4: Qualitative interviews with four cohorts of managers from a variety of socio-demographic and education backgrounds (degree/ non-degree; clinical/non-clinical) in a variety of roles in different organisations.

Stage 5: Questionnaire Survey focusing on basic career histories and experiences of TM and mt.

Stage 6: Quantitative (questionnaire) and qualitative (interview) examination of TM in five high performing organisations

1.7 Structure of the Report

Chapter 1 sets out background material, introduces TM, and outlines the main stages and methods of the project and the structure of the final report.

Chapter 2 reports the main findings of a literature review of TM.

Chapter 3 examines the earlier initiatives of 'mt' and the current 'TM' initiative in the NHS.

Chapter 4 reports the main themes arising from Focus Groups on TM in one locality.

Chapter 5 outlines a documentary analysis of national and SHA documents on TM.

Chapter 6 examines interviews with stakeholders with a national overview of TM and with SHA respondents.

Chapter 7 reports the results of a national survey of NHS managers on TM in the NHS.

Chapter 8 provides the 'depth' element to the 'breadth' of the survey with interviews with four cohorts of managers in the NHS.

Chapter 9 aims to explore the links between TM and organisational performance by focusing on high performing organisations in the NHS.

Chapter 10 summarises the main findings, explores some of the main themes that arose from a triangulation of findings from different stages, and sets out the implications for managers and recommendations for further research.

2 Literature Review

2.1 Introduction

This literature review looks at the topic of talent management and explores the published literature in public services and commercial sectors. The term 'talent management' is widely used in the service sector but inconsistently applied, and does not correspond to a single well-defined area of academic activity. We have therefore taken a pragmatic approach and considered the full range of approaches taken from academic journals (experimental and non-experimental research) and the grey literature (to show how the issue is framed by professional bodies. The aim of the literature review is to contribute to a critical examination of the impact that Talent Management makes to the development of an effective managerial workforce.

The environment for many organisations is global, complex, dynamic, and highly competitive⁽¹⁰⁾. In addition many organisations are facing challenges from talent flow, managing different generations of employees and a shortage of needed competencies. This is despite the current global and national economic slowdown. Organisations, including the NHS, are searching for individuals who can effectively manage through this complex, challenging, changing, and ambiguous environment.

2.2 Method

Relevant literature relating to TM was identified in a number of ways. A targeted review of the literature over the past ten years was undertaken at the beginning of the project. This was supplemented throughout the duration of the project by continuous monitoring of other relevant internet based information sources and in-house bulletin/alerts.

The review of the literature on TM was undertaken during April 2009 by library staff at Health Services Management Centre (HSMC), University of Birmingham. The searches were done using the following databases:

web of science, isi, ebSCO, Proquest, OvidSP, HMC, OvidSP, Medline, Medline, Cinahl and CSA-Assia.

The first search strategy used the following search terms:

talent management; managing talent; succession planning; human capital management; human capital development; human resource planning; leadership development.

However, this generated several thousand hits, which was beyond the resources of the project to filter for inclusion/exclusion.

As a result, it was decided to use the single term 'talent management' and confine the search to the previous 10 years of publications in order to identify the key documents on the subject. This resulted in a total of 620 abstracts using the same databases. The abstracts were reviewed independently by two members of the project team, and a total of 103 documents were identified for retrieval, analysis, and where relevant included in the review that follows.

In order to keep up to date with policy and other developments in TM the project subscribed to a range of relevant internet alert services. These included:

- NHS Institute Alert (monthly);
- NHS Employers NHS Workforce Bulletin (monthly);
- NHS Confederation Health Policy Digest (monthly);
- Central Office of Information's News Distribution Service (NDS).

Health related news and alerts about new publications from the Department of Health were provided by the library staff at the HSMC through its 'Daily Digest' bulletin.

2.3 Definition

There are many definitions of what makes a talented manager, for example concepts such as potential, achievement, ability to deliver the organisation's strategy, leadership and superior behaviour⁽⁴⁵⁾. One definition is that an exceptional manager is one who can make a strategic difference⁽⁴⁶⁾. But what, then, is the difference between succession planning and talent management? The former can be defined as identifying future potential leaders to fill key positions⁽⁴⁷⁾. It can also be seen as⁽⁴⁸⁾

'... a process by which one or more successors are identified for key posts (or groups of similar key posts), and career moves and/or development activities are planned for these successors. Successors may be fairly ready to do the job (short-term successors) or seen as having longer-term potential (long-term successors)' (p. 2)

The CIPD has produced some broad definitions for both 'talent' and 'talent' management⁽²⁾:

'Talent consists of those individuals who can make a difference to organisational performance, either through their immediate contribution or in the longer term by demonstrating the highest levels of potential.' (p. 2)

'Talent management is the systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation.' (p. 2)

In these definitions, a person's human capital seems to be conflated with the person himself or herself. It is as if some people are worth investing in and others (implicitly) not.

There are two problems when attempting to define talent management⁽⁴⁹⁾. First, it is not clear whether 'talent' refers to a narrow section of the workforce (such as senior leaders) or to the whole workforce itself. Second, talent management could refer to a narrow range of activities around attracting and developing talent but others apply it to a wider range of activities and processes including motivating, rewarding and retaining staff. So talent management could be taken here to encapsulate HR activities for the whole staff group within an organisation. Garrow and her colleagues argue for a more focused approach to talent management and its definition⁽⁴⁹⁾. This call is supported by others who see that talent management can be regarded in three particular ways: as the processes that HR departments undertake; as a focus on developing talent pools to facilitate the flow of suitably skilled staff throughout the organisation; or, as a focus on talent generically where highly competent performers are hired by an organisation⁽¹⁾.

The first approach describes talent management as the whole range of activities associated with human resource departments. These encapsulate recruitment, selection, education, development, and succession management^{(1); (50); (51); (52); (53)}. Talent management is about doing what HR departments have always done but it is about doing better, faster or in a more comprehensive manner perhaps by using the Internet or outsourcing certain activities. Talent management and human resource management appear to be synonymous in these definitions.

The second perspective focuses on the concept of creating and maintaining talent pools within an organisation^{(54); (55)}. These talent pools are created and fed by TM processes. The aim is to ensure that there are adequate numbers of employees for jobs and vacancies throughout the organisation. This is very similar to workforce and succession planning, also known as human resource planning⁽⁵⁶⁾. Talent management here includes recruitment and selection processes⁽⁵⁷⁾, and predicting projecting future staffing requirements and managing the flow of employees through the organisation. This of course tends to be internally focused looking at what is going on within the organisation rather than including the external labour market. Schweyer (p20) states that the first priority in TM is to understand the internal workforce⁽⁵⁸⁾. This approach used to be known as "manpower" planning and involved modelling staffing flows^{(59); (60); (61)}. The planning process is based on analysing and modelling the flow of staff through jobs due to growth in the organisation, loss of people and posts, and other issues.

A third perspective on TM focuses on talented people (generically) ignoring organisational boundaries and focusing on all positions within the company. Talent refers to high performing individuals or individuals with high potential talent. Talent is a resource to be managed according to performance levels. Therefore the aim is to recruit and reward highly competent performers, regardless of their role or indeed the organisation's needs. In other words talent is seen as good; talent pools are developed and managed but without a specific focus on workforce planning issues for specific jobs. Employees are classified by performance level (e.g., top, competent, and bottom performers, are denoted as "A", "B", and "C" levels, respectively). "C" players are terminated: the "War for Talent" approach or "topgrading" the organisation via exclusively hiring "A" players^{(3); (8); (62)}. Walker and LaRocco argue that this is a flawed approach to talent management due to problems of selection, grading, the "self-fulfilling (and self-deluding) nature' of an elite talent pool, and the impact on the 80-90% of 'untalented' B and C groups⁽⁶³⁾.

A fourth definition describes talent management as '*a set of tools and technologies that help good organizations make good decisions about talent.*'⁽⁶⁴⁾ (p.3 Of course, there is more to it than this as the organisation again objectifies and commodifies its human resources. It could be argued that it is people (and not just talent) that it should be investing in. Ulrich and colleagues suggest that talent management is a '*mindset*'.⁽⁶⁴⁾

'As talented individuals are at the centre of an organisation's success, the question attached to every decision is "what impact will this have on our critical talent?" or "What role does talent play in this issue?" (p. 3)

Another approach looks at talent management as an amalgam of succession planning and leadership development⁽⁶⁵⁾. Conger and colleagues coin the phrase succession management and claim that there are a number of rules for this to be successful: focus on development; identify the 'linchpin positions' (jobs that are essential to the long-term health of the organisation); keep things transparent and open; measure progress regularly; and keep things flexible. They cite a number of examples in American blue chip companies where these succession management actions are embedded although no thorough analysis is presented to demonstrate its link with corporate success. Another theme in their article is the imperative to identify the top (500) managers and concentrate the talent management activities on this group. Succession management is not seen as something for all the workforce; it is for those who have been identified (through assessment processes) as having 'executive potential'⁽⁶⁵⁾. This top-performing 'cream' is construed as critical for organisational success, yet it could be argued that even a lowly paid healthcare assistant within the NHS can have a major impact on the performance of the hospital.

2.4 Talent management: hard or soft Human Resource Management?

The emergence of talent management processes within the NHS can be seen in the context of the move, within public services, towards private sector management practices including acceptance of 'the cult of leadership'⁽⁶⁶⁾. For example, during the 1980s and 1990s, the UK government encouraged public sector managers to follow the behaviour of their private sector counterparts by replacing traditional methods and ethos of public administration by supposedly superior private sector practice^{(67); (68); (69)}. This has been supported by the development of human resource management (HRM) and the HR function within organisations. Legge⁽⁷⁰⁾ makes an important distinction between the 'hard model' based on "*utilitarian instrumentalism*" and a 'soft model' based on "*developmental humanism*" (p.66). This has implications for the different approaches to talent management. It is argued that many private sector companies, in reality adopt a 'hard HRM approach' to managing their human resources. Truss and colleagues⁽⁷¹⁾ find that:

'The rhetoric adopted by private sector companies frequently claim to embraces the philosophy of the soft, commitment model while the reality experienced by employees is more concerned with strategic control, similar to the hard model.' (p. 53).

Hard HRM stresses "*the quantitative, calculative and business-strategic aspect*" of managing the "*headcount resource*" in as "*rational*" a way as for any other factor of production (utilitarian-instrumentalism)^{(70); (72)}. In other

words humans are resources to be planned and managed in the same way as any other organisational resource. Hard HRM focuses on the importance of “*strategic fit*”, where human resource policies and practices are closely linked to the strategic objectives of the organisation (external fit), and are coherent among themselves (internal fit) with the ultimate aim being increased competitive advantage^{(73);(74);(75)}. Within the hard HRM perspective, talent is an undifferentiated good. Developing talent is seen as critical because it is the job of an effective human resource department to manage everyone to high performance^{(63); (76)}. The other reason it is critical is because demographic and business trends mean that there is a “shortage of talent” and therefore as a commodity it is seen as valuable^{(77); (78); (79)}. This approach has parallels with the resource-based view of the firm. A successful strategy can be seen as a ‘continuing search for rent’⁽⁸⁰⁾, where rent is defined as return in excess of a resource owner’s opportunity costs⁽⁸¹⁾. Resources may be classified as land, labour and capital (organisational, tangible and intangible)⁽⁸²⁾. In a review on the resource-based view of the firm Mahoney and Pandian set out the link between talent as a resource and successful competitive strategies.⁽⁸³⁾

In contrast, soft HRM is closely aligned with the High Performance Work Systems approach. Becker & Huselid conceptualize HPWS as a set of distinct but interrelated HRM practices that together select, develop, retain, and motivate a workforce⁽⁸⁴⁾. This workforce should possess superior abilities and apply these to work-related activities. These resulting work-related activities result in the firm achieving sustainable competitive advantage. This occurs through the link between employee behaviours and output and the achievement of superior intermediate indicators of firm performance. They argue that HPWS involves organisations investing in their pool of human capital to ensure that employees are well trained, skilled and empowered to conduct their jobs. HPWS involves selective staffing, self-managed teams, decentralised decision making, extensive training and management development, flexible job assignments, open communication and performance related pay. These elements are interdependent and the inclusion of one approach requires the inclusion of the others. Hence the CIPD approach to talent management which involves a number of individual HR processes, which added together make a talent management strategy⁽⁸⁵⁾. These include: recruiting people with talent; rewarding talented recruits; organising groups of talent (banks and pools); ensuring diversity of talent; appraising talent (and performance management); developing talent; deploying talent; tracking talent; and retaining talent. This of course falls into the trap that talent management merely describes everything that an HR department does.

2.5 Reasons given for the importance of talent management

Talent management is said to be important because of the role of top performers in the success of the organisation. There is also the issue of the unpredictability of workforce planning for senior posts and the costs of over-shooting or under-shooting the supply of suitable candidates for these posts^{(63); (86); (87)}. It is also argued that during economic downturns it is difficult to conceive that there is a serious talent crisis given the increasing levels of unemployment⁽⁸⁸⁾. There are other challenges, which will reduce the supply of talent, it is argued, due to the ageing of the workforce and the imminent retirement of the first cohorts of the 'baby boom' generation. Rappaport goes on to argue that in the United States (US) health care system many skilled professionals are projected to become increasingly scarce⁽⁸⁸⁾. He puts forward a number of strategies to deal with this issue including: better workforce planning; creating new roles, new career paths and employment arrangements; adopting creative recruitment strategies; aligning pension and health care benefits with workforce needs; updating performance management and reward systems; reconfiguring training and development; implementing a knowledge management strategy; and aligning the culture of the organisation with workforce needs.

Talent management is also seen as a generator of innovation and business ideas⁽⁸⁹⁾. It is argued that finding and developing the next generation of innovators is an important driver of growth. The crucial activity is to identify innovators and allow their creative talent to grow. Cohn argues that two crucial aspects of this process is the need to have supportive mentoring and peer-networks for these innovators⁽⁸⁹⁾. Once these innovators have been identified and supported appropriately, it is claimed, they then become the drivers for organisational growth and innovation.

2.6 Talent management strategies

It is argued that there are a number of issues that need to be considered when organisations are trying to implement a successful talent management strategy⁽⁹⁰⁾ including:

- *'Having an agreed, organisational-wide definition (and a shared language) of talent and talent management.*
- *Having a proactive, strategic approach to talent management is beneficial in terms of developing a pool of talent as a resource to meet identified needs.*
- *Support for talent management must flow from those at the very top of an organisation and cascade throughout.*

- *Engaging line managers from an early stage is critical to ensure that they are committed to organisational approaches to talent management.*
- *Talent management can be used to enhance an organisation's image and supports employer branding in the labour market as well as providing a means of enhancing employee engagement to improve retention.*
- *Talent management activities should be developed with other HR policies and practices for a joined-up approach. Developing talent may be based on a blend of informal and formal methods.*
- *Processes must be developed to track the performance and progress of those identified as talent.'* (p.70)

The CIPD sets out a number of individual HR processes, which added together make a talent management strategy⁽⁸⁵⁾. These include: recruiting people with talent; rewarding talented recruits; organising groups of talent (banks and pools); ensuring diversity of talent; appraising talent (and performance management); developing talent; deploying talent; tracking talent; and retaining talent.

The other approach to the talent management process is based on the notion of a talent management hierarchy⁽¹⁾. Thus in order of strategic perspective, talent management activities can be divided into:

- Strategy to provide sustainable competitive advantage (what market opportunities exist and which organisational resources yield advantage?)
- Strategy implications for talent
- Talent pool strategy
- Talent management systems
- Talent practices

In Conger et al's approach to succession management, the emphasis is on internal promotion of talented managers⁽⁶⁵⁾. They claim that on test of a successful succession management strategy is in its ability to fill important positions with internal candidates. They cite the example of Dow Chemicals where an internal hire rate of 75% is seen as a success. Although little mention is made of whether this is across the managerial levels or at one particular executive level. Dow also claims to have a much lower attrition rate of senior managers than the industry norms.

It has also been argued that the best approach to talent management is to involve the talented new recruit or member of staff in designing their own development experience⁽⁹¹⁾. It is argued that companies need to be innovative in developing new talent and not copying other schemes. New and prospective hires need to be told what it is like to work in the organisation and what it is that makes the organisation unique. Erickson and Gratton talk of the importance of the "signature experience" that tells the right story about the company⁽⁹¹⁾. In doing this talent who share the values and enthusiasm for the organisation are selected thereby creating the foundation for highly productive employee-employer relationships. Thus differences in talent management approaches should be applauded because these are seen as another way that companies can attract the 'right' employee and differentiate themselves from other competitors.

2.7 Managing talent is not just about talent

Much emphasis is placed on identifying, recruiting and developing talent. However there are a number of challenges in dealing with people designated as "untalented", the so-called C-category employees⁽⁶²⁾. Whilst this non-talent management is outside the scope of this review, it is worth noting that failure to manage this group can be a problem. Axelrod et al note that these C managers can include people who were once A- and B-managers but who have ceased to perform⁽⁶²⁾. Dealing with these people is fraught with emotional, ideological and practical difficulties, but is an essential part of an organisation's talent management strategy. So Axelrod and colleagues argue that talent management is about five things⁽⁶²⁾:

1. Embracing a talent mind-set, and make talent management a critical part of every manager's job.
2. Creating a winning 'employee value proposition' that provides a compelling reason for a highly talented person to join and stay with your company.
3. Rebuilding recruiting strategies to inject talent at all levels, from many sources, and to respond to the ebbs and flows in the talent market.
4. Weaving development into the organisation by deliberately using stretch jobs, candid feedback, coaching, and mentoring to grow every manager's talents.
5. Differentiating the performance of people, and affirming their unique contributions to the organisation (this includes and goes beyond dealing explicitly with low performers).

2.8 Measuring and recording talent

It is claimed that only 25% of managers systematically identify and monitor important talent metrics⁽⁹²⁾. The common mistakes in measuring talent management are cited as:

- measuring the wrong things;
- focusing on measuring everything rather than the consequential few metrics;
- concentrating on analysing summary data (such as turnover rate) without acknowledging that averages can mask significant variations;
- not using the data to make better decisions.

Foreman goes on to set out the stages of talent management before describing the measurement challenges of each stage⁽⁹²⁾. These are: in workforce planning, the whole talent pool (all employees) should be forecasted, prioritized and orchestrated to ensure success (rather than just future CEO pools). In talent acquisition the important question is 'can we attract top talent?' rather than 'what is the time to hire, cost to hire and quality of hire'. In talent development measurement should be focused on workplace learning, 'stretch' assignments, teams, coaches and communities of practices. What tends to be measured however is percent of payroll spent on training and the time spent on training. In talent deployment metrics should look at what will develop a top employee to the next level. This, it is argued, is not an area that most companies look at. In talent retention most companies look at the staff turnover rate. It is argued that while this is an important figure, perhaps a better focus should be on whether top talent can be retained.

Others argue that a more analytical approach should be adopted in talent management and workforce planning as a whole⁽⁸⁶⁾. This would involve managers creating workforce forecasts with confidence intervals and feeding these into simulation models where the impact of different scenarios can be assessed. One critique of this approach is that it is very quantitative but requires quite a subjective assessment of the issues that might impact on the talent turnover process. There must be questions about the robustness of approaches, which objectify subjective data.

Cohn and colleagues discuss the dangers of leadership competency models to measure and classify talent within organisations⁽⁸⁹⁾. Their argument is that they are widely used as the basis of talent management processes and provide a common language to help managers discuss emerging talent in their organisations. However they can also lead to 'sameness' by eroding the conditions in which unique points of view can arise. This, it is argued,

emphasises the formal at the expense of the informal. The selection of leaders also suffers as the promotion vetting processes select individuals who closely resemble their peers and bosses. Unique attributes and a willingness to deviate from company norms are not recognised or developed but systematically removed from the organisation.

2.9 Conclusion

Talent management is a contested term and it is this lack of an agreed approach which can cause confusion. It is also clear that TM can adopt a hard or soft HRM approach and in exploring the relevance of TM it is important to understand which approach is appropriate to the NHS ethos. There is also an issue as to what is talent and is it simply decided on leadership potential? Many organisations see talent as a wider concept and talent management as the whole process of acquiring, developing and managing these resources. So for example, the CIPD defines talent as a complex amalgam of employees' skills, knowledge, cognitive ability and potential. Employees' values and work preferences are also of major importance⁽⁸⁵⁾.

Should the NHS and public sector are adopting practices from the private sector without sufficient tailoring to their public sector context and the public service ethos? Particularly, if the TM approach is based on 'hard HRM' rather than softer approaches drawing on the resource based view of the organisation. There appears to be an assumption that the adoption of talent management will make the NHS more effective yet the literature suggests that TM is vague and unproven in the private sector, with multiple approaches and confusion over definitions and metrics. Why should this approach work in the public sector? Much of the literature focuses on top management and leadership. What does this mean for the rest of the work force and does this form of talent management apply to those who are talented in other ways?

3 Talent Management in the NHS 1948-2011

As we saw in Chapter 1, the term 'Talent Management' was not used in the NHS until 2004⁽²⁴⁾ although the term 'talent' had appeared in earlier Department of Health (DH) documents⁽¹⁹⁾. However, while TM may be new, the NHS has long been concerned about managing talent (mt). This section aims to summarise mt and TM within the wider context of management and leadership development and workforce planning, and the changing institutional landscape of the bodies responsible for staff development including the NHS Training Authority (NHSTA), NHS Training Directorate and the NHS University.

3.1 'mt' in the NHS

It was recognised in 1948, after the establishment of the NHS, there needed to be a formal process for recruiting and training the administrative staff need to run the service. In the 1950s the Hospital Administrative Staff College of the King Edward's Hospital Fund for London (now known as the King's Fund) was running programmes to support the development of administrative, nursing and catering staff in the NHS. Saunders⁽²⁵⁾ identifies that, (in 1955) it was developing a scheme to provide the NHS with '*well-trained administrators who would be competent to fill senior administrative posts in years to come*'. (p. 1)

A year later, the details of this scheme were set out in the Ministry of Health paper HM (56) 32⁽⁹³⁾ and, Saunders⁽²⁵⁾ argues that many of the principles have remained in the last 54 years. The arrangements provide for:

1. '*the selection and training for senior posts of the younger officers in the hospital service who are showing promise*;
2. '*the recruitment and training annually of a small number of university graduates and other professionally qualified entrants who are attracted to the hospital service as a career and who might be expected to be capable of future promotion to senior posts.*' (p. 2)

The first intake to the Management Training Scheme (MTS) was in September 1956, comprising 14 trainees (12 males and 1 female of this cohort completed the programme.⁽²⁵⁾ Interviews with managers from Exworthy and MacFarlane's project⁽⁹⁴⁾ suggest that in the past many senior managers stayed in post for long periods of time and they regarded it as a key part of their role to train the next generation. This was reflected in Regional Staffing Officers (RSO), the National Staff Committee for Administrative and Clerical Staff (NSCA&C) and the Standing Committee

management Education and Training (SCMET). RSO were often regarded as 'king makers' through recommending individuals for shortlists and placements. NSCA&C developed policies on appraisal and management development and supervised MTS. SCMET allocated funds from Department of Health & Social Security (DHSS) for management development, including funds for the health care management units at Birmingham, Manchester, King's Fund and Leeds.

These functions were taken over from 1981 by a Special Health Authority- the NHS Training Authority, chaired by Chief Executive of the NHS, Sir Len Peach, who had a background in HR Director for IBM. In 1983 MTS was renamed the National Management Training Scheme in the light of the introduction of general management following the Griffiths Report.⁽⁹⁵⁾

In 1986 the NHSTA published the policy document '*Better Management Better Health*'⁽⁹⁶⁾. It set out the proposals to replace the National Management Training Scheme with the Graduate Management Training Scheme (GMTS 1) targeted at graduates and in-service candidates with little management experience. It was seen as being part of a wider National Accelerated Development Programme, which also contained GMTS II and GMTS III for the development of managers with more management experience. GMTS 1 included: formal education leading to a MSc, a 'Cooks Tour' of the NHS within a health district, placement in a managerial job, placements in health or non health organisations, plus, a month within an education centre.

In 1990, the NHS Training Directorate (replacing the NHSTA), took over national responsibility for the running of the scheme. A Consortium comprising the management consultants, Price Waterhouse, the Institute of Health Services Management (IHSM), and IHSM Consultants Ltd reviewed and redeveloped all aspects of the scheme. This led to the introduction, in 1993, of the 'National Management Training' scheme. It had national standards but was delivered locally with regional co-ordination and delivery. The aim was to equip trainees with the skills and behaviours and underpinning knowledge so that trainees were able to do what managers need to do⁽²⁵⁾. Sir Alan Langlands (NHS Chief Executive 1994-2000) launched a national Management Development programme and provided each region with resources to develop the managerial workforce.

In 1998, the scheme and its graduates had to embrace and operate within a changing NHS policy context including the white paper '*The New NHS: modern and dependable*'⁽⁹⁷⁾ and the Green Paper '*Our Healthier Nation*'⁽⁹⁸⁾. There was now a National Director for the scheme but trainees' contracts

were held by individual regions or by a host organisation on behalf of their Region.

The importance of human resources to the delivery of health services was recognised in a white paper entitled 'Working together: securing a quality workforce for the NHS'⁽⁹⁹⁾. This document set out actions to improve the quality of NHS services and the quality of the working life of NHS employees. It was the result of a consultation and stressed the importance of human resources when planning work in NHS priority areas. It had a target of creating a healthy and involved workforce. The Health Committee (1999) recommended a thorough review of the health service workforce. This recommendation was accepted⁽¹⁸⁾ and the government published a blueprint for workforce planning: '*A Health Service of All the Talents: Developing the NHS Workforce*'⁽¹⁹⁾. Interestingly, despite the title, the document does not mention 'talent' after the introduction and its main focus is on future workforce planning arrangements.

From 2000 onwards the authority and influence of Regions began to diminish. The NHS Leadership Centre was established in 2001, as part of the Modernisation Agency (MA), and was responsible for promoting leadership development across the NHS. These included the Graduate Training Scheme, Breaking Through and 'Gateway to Leadership', which was launched in 2002 (see below).

The Health Committee (2007)⁽²¹⁾ concludes that there are a number of weaknesses in the current workforce planning system (para. 148). The 'boom and bust' spending and constant reorganisation, including the establishment and abolition of Workforce Development Confederations (WDCs) within 3 years, resulted in a '*disastrous failure of workforce planning*' (para. 289). The 24 WDCs were established in 2001, and overseen by the 8 Regional Offices until they were replaced by SHAs in 2002. In 2004 WDCs were merged with the 28 SHAs. In 2006 the number of SHAs were reduced from 28 to 10, but the Health Committee heard '*serious doubts about whether the new SHAs have either the will or the skill to undertake effective workforce planning*' (para 88). Mirroring the fate of WDCs, the MA was closed in 2005 although some of its functions were subsequently resumed with the creation of the NHS Institute for Innovation and Improvement (NHSIII). The removal of the WDCs and the MA left gaps which remain unfilled. Workforce planning appears to remain a secondary consideration for many organisations. '*Despite great efforts in some quarters, the workforce planning system is not performing noticeably better than 8 years ago*' (para. 154). The Committee proposes '*one key change: workforce planning must become a priority for the health service*' (para. 292). Much of the focus of workforce planning was on the clinical workforce,

but the Health Committee states that managers are a crucial component of the health service workforce. However, the quality of managers is highly variable and the absence of minimum standards or training requirements is a concern. NHS organisations need to recruit [no mention of retain!] managers of a high calibre. They should ensure that all managers are appraised and have access to relevant training (para. 224) (see Imison et al⁽¹⁰⁰⁾).

3.2 TM in the NHS

In 2004 the NHS adopted a new approach to identifying and developing managers with the establishment of a national talent management team whose aim is to '*identify and position high potential individuals to have a disproportionately positive impact on the organisational performance*'. It stated that '*good leadership at every level is a significant factor in improving the quality of patient care and the health of the population*', and aims to establish an executive talent pipeline that identifies, tracks, develops, positions and retains critical leadership talent within the service⁽²⁴⁾.

This was linked with the Chief Executive of the NHS, Nigel Crisp's (NHS CE 2000-2006) concern over equality, He set out a 10-point race equality action plan, with half the plan about improving services for minority ethnic communities and the other half concerned with developing staff, an 'Equality Tsar', and setting up the 'Breaking Through' programme.⁽¹⁰¹⁾

In July 2005, the Leadership Centre and Modernisation Agency were abolished. The newly created NHS Institute for Improvement and Innovation became responsible for the three main initiatives of the TM programme:

1. Gateway which identifies individuals from outside the NHS with the potential to fulfil director level roles;
2. The Management Training Scheme (MTS), which provides training and support as well as placing individual trainees in a series of key roles in PCTs and trusts over a period of two years; and
3. Breaking Through, which is a programme that provides a series of opportunities for Black and Minority Ethnic employees⁽³⁰⁾.

In February 2006, the 50th anniversary of the NHS graduate training scheme the NHSII undertook a review of its leadership programmes. The annual intake of MTS was increased from 70 to 90 to reflect the growing demand from an expanding NHS. The overall aim of the scheme remained⁽²⁵⁾:

'to recruit graduates and comparably qualified individuals annually onto a two-year, full time scheme that aims to develop the future leaders of the NHS, and in particular its Chief Executives and Directors.' (p. 25)

Graduates were awarded an MSc in Healthcare Leadership and Management awarded jointly by the Universities of Birmingham and Manchester²². Gateway was re-launched in 2007.

The introduction of the Leadership Qualities Framework was developed to set the standard for outstanding leadership in the service by describing the qualities expected of existing and aspiring leaders. The framework has been used to underpin leadership development, for individuals, teams and organisations⁽¹⁰²⁾.

In his first interview as NHS Chief Executive, David Nicholson gave one of his three priorities as leadership⁽¹⁰³⁾:

'... we are not producing people with the right skills to lead organisations. Unusually, in the developed world we have few clinical people in charge of organisations.'

Finally, there are not enough women and black people in senior positions in the NHS⁽¹⁰³⁾.

Clare Chapman moved from being Group personnel director at Tesco, to be workforce director-general at the DH in 2007. Giving evidence to the Health Committee, she was clearly aware of the need to attract talent from outside the NHS, and identify and develop indigenous NHS talent⁽¹⁰⁴⁾:

'One would assume, given over one million people, that there are some extraordinarily good managers, or people who have got the capability to be extraordinarily good managers.'

She pointed to the need for development programmes and made active talent spotting a priority. Echoing one element of the Griffiths Report and Clare Chapman's move from Tesco, Lord Hunt signalled the government's intention to bring in more private sector expertise⁽²³⁾.

During 2007, David Nicholson asked all SHAs to develop an approach and a programme for aspiring chief executives. The Operating Framework for the NHS in England 2008/09 identified leadership as one of the enabling strategies for service improvement. In particular, it called upon SHAs to take lead responsibility for talent and leadership management across the healthcare system⁽¹⁰⁵⁾. It articulated the Department of Health's commitment to the introduction of talent and leadership plans at regional

level in 2008/09, followed by local introduction in 2009/10, and committed the Department to producing guidance for the NHS on talent and leadership planning. It states that spotting more future leaders is one element of what good leadership is all about. All providers are expected to spot and develop more leaders with a greater diversity of backgrounds and experiences (p. 34).

The Darzi Report⁽¹⁰⁶⁾ stressed the importance of the NHS workforce, leadership and unlocking talent, arguing that leadership had been a neglected component of the reforms until relatively recently. It proposes a number of policies to develop leadership including: incorporating leadership development into professional education and training; developing a range of leadership qualifications up to master's level; identifying and supporting the top 250 leaders; producing guidance on talent management; creating a clinical leadership fellowship scheme; removing the barriers to allow a greater proportion of leadership posts to be filled by clinicians, women, people from black and minority ethnic (BME) groups and individuals with experience beyond the NHS; and establishing a National Leadership Council (NLC). According to the related document, *A High Quality Workforce*⁽¹⁰⁷⁾,

'... our approach to reforming the workforce planning, education and training system mirrors the approach for the NHS itself – a belief that quality is best served by devolving decision making as close as possible to the front line in an environment of transparency and clear accountabilities'. (p.31)

The report sets out a 'bottom-up approach' and 'producer-led' to NHS workforce planning (see Imison et al⁽¹⁰⁰⁾).

NHS Interim Management and Support (NHS IMAS) was established in March 2008 by David Nicholson to encourage and facilitate the NHS to use the wealth of skills already available to it. NHS IMAS supports organisations at all stages of development, whether going from 'good to great', working on service reconfiguration and other developments, or supporting those organisations facing issues or challenges.

The NLC was set up in 2009. It has five workstreams, with the first four concerned with managers: Top Leaders; Emerging Leaders; Inclusion; Clinical Leadership and Board Development. The 'Top Leaders' programme is designed to ensure that the NHS has a supply of leaders for the most senior posts. There are circa 800 participants (an increase on the original figure of 250) on the current NHS Top Leaders list. Participants are split between "field" and "pool", with the former being those currently in the most senior and complex roles, while the latter are those who have been

deemed to have demonstrated both high performance and potential to succeed into a field post in due course. The Emerging Leaders programme focuses on inspiring and enthusing potential leaders to come forward and develop their talent. The Inclusion programme is working beyond developing leaders and defining leadership posts, focusing instead on improving incentives and removing barriers to leadership roles for clinicians, women, BME, and talent from outside the NHS and encouraging people from within these groups to apply for leadership posts. Finally, the Next Stage Review recognised that effective clinical leadership is critical if the NHS is to place quality of care at its heart. Key work programmes include: develop a generic leadership framework for all clinicians; develop the NHS leadership currency and accreditation process; attracting clinicians to leadership; curricula development ; and offering clinical Leadership Fellowships. It set out its short term aims, which include 'at least three appointable candidates apply for each senior management vacancy' and 'success measures for 2015'⁽³²⁾ (pp10-11).

In January 2009, the DH published its 'guidance for NHS talent and leadership plans' titled *'Inspiring Leaders: Leadership for Quality'*⁽¹⁰⁸⁾. According to David Nicholson, the NHS is only just beginning to grasp the importance of leadership. *'We have not systematically identified, nurtured and promoted talent and leadership'* (p. 5). The purpose of the guidance was to provide a best practice framework for the development of leaders across healthcare (p. 4). The document required that SHAs had a talent and leadership plan in place by the end of July 2009, and stated that these plans would form part of the SHA Assurance process (p. 11; see Chapter 5).

3.3 TM in a cold climate?

Almost as soon as TM was seen as an organizational imperative, TM entered a cold climate with a 'double whammy' of the need to make management savings and organizational change. The need to release 'unprecedented levels' of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over the three years was stated in the NHS Chief Executive's Annual Report for 2008/09⁽¹⁰⁹⁾, and in the NHS Operating Framework of 2010/ 2011⁽¹¹⁰⁾. In June 2010, Health Secretary Andrew Lansley told the health service it must save at least £222m in management costs this year. Revisions to the 2010-11 Operating Framework say the NHS must also cut its management costs by 46% by 2013-14, as part of measures to go '*further and faster*' to achieve savings than had previously been envisaged.

Second, the NHS Workforce Review Team (WRT) was replaced by the Centre for Workforce Intelligence (CfWI), which is the new national authority on workforce planning and development providing advice and

information to the NHS and social care system operated by Mouchel⁽¹¹¹⁾. The Department of Health commissioned the NHS WRT to run a pilot process in the transition towards the CfWI. This was in order to provide a national overview of five-year SHA workforce plans, which were formally produced for the first time in 2009–10. Moreover, as accurate data is critical for successful workforce modelling, the CfWI is mapping and reviewing what information is available, and has identified more than 60 data sources and collections to date. TM is similar to workforce planning in some ways. For example, according to one overused description⁽¹⁰⁰⁾, workforce planning is about '*getting the right staff with the right skills in the right place at the right time*' (p. 3). However, despite this, TM is rarely mentioned in discussions of 'workforce'. For example, the CfWI appears to have few clear links to TM, despite one of its three key strategic aims being to provide leadership within the system (also see above, mt).

The most significant organizational change was signaled in the Coalition government's White Paper, '*Equity and Excellence*'⁽¹¹²⁾, which set out plans to abolish PCTs and SHAs. Finally, under the review of 'Arms Length Bodies' (ALB), the NHS Institute is set to be abolished. Moreover, it is reported that the NHS Leadership Council is being replaced by a 'think tank' which will be called the NHS Leadership College.⁽¹¹³⁾ On 5th July, Health Secretary Andrew Lansley marked the 63rd birthday of the NHS by announcing plans for a new national Leadership Academy. This will bring together in one place the latest thinking and best practice on leadership, and will nurture talent regardless of discipline or seniority by giving all staff – clinical and non-clinical the same opportunity to develop leadership skills.^{(114); (115)} Moreover, the document stresses a 'bottom up' approach:

'A top-down management approach led by the Department of Health does not allow accountability for decisions affecting workforce supply and demand to sit in the right place. It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training.' (p. 40)

Finally, there have been some changes in leadership associated with TM. In January 2011 Ross Baglin resigned as Director of Leadership at the DH, and was replaced by Jan Sobieraj, who is seconded from the post of NHS Sheffield CEO. Finally, Clare Chapman resigned as NHS Workforce Director in July 2011. She was replaced on an interim basis by Jan Sobieraj, with a team of three (Richard Jeavons, Karen Lynas, Charles Lister) to replace him and former Deputy Director of Leadership, Steve Collins.^{(116); (117)}

The estimated number of staff whose current employment is affected by these reforms is around 90,000, and developing an HR response is more

complex than for any other past reorganisation⁽¹¹⁸⁾. The 'HR letter' continued that Sir David Nicholson has said that there will be broadly three categories of staff in organisations directly affected by the changes: those who wish to leave immediately, those who wish to stay in post to support the management of the transition, and those who wish to be part of the future system. For staff in the first category, a national voluntary severance scheme entitled 'Mutually Agreed Resignation Scheme' (MARS) has already been made available. The first round of this scheme closed at the end of October/early November 2010 and around 2,200 staff have been approved to leave under the scheme across England. The second and third categories require a complex series of moves across the NHS, DH and ALBs at a time when significant management cost savings will need to be delivered. These moves may involve TUPE ['Transfer of Undertakings (Protection of Employment) Regulations'] or the Cabinet Office 'Staff Transfers in the Public Sector Statement of Practice' (COSOP). In order to support tomorrow's leaders the DH and the NLC have reviewed their priorities and realigned resources to enable transition. The NLC's advice, 'Governing for Quality', is very timely and is being adapted further for use by GP Commissioning Consortia. The National Equality and Diversity Council will also be providing guidance on what provider and commissioning boards can do to ensure a focus on fairness and equality is retained during the changes. There is also a commitment to maintaining talent and leadership capability and to making people available to support new structures. The NLC's Top Leaders and Emerging Leaders programmes are being adapted so they can support people to make these moves and inform employers efforts to retain key leaders. The DH and ALBs continue to invest in the development of leaders to ensure capability is strengthened to effectively lead and manage change through transition and into the future. In reviewing resources and priorities, the DH will extend its provision of leadership development including programmes via the National School of Government and internally led development solutions.

According the newly appointed DH Permanent Secretary, Una O'Brien, retaining talented PCT and SHA managers in the system is 'top priority'. This gave rise to some cynical comments of the 'cruel irony' of 'closing the barn door after the horse has bolted'⁽¹¹⁹⁾. Moreover, it was claimed that management posts were shed without full consultation, with individuals being made redundant in addition to the MARS scheme⁽¹²⁰⁾. At the same time, it was reported that PCT CE's had been given national roles arranged by IMAS, but (largely anonymous) critics point to the lack of advertising, transparency and process, arguing that this is a 'backdoor method of appointing friends and cronies' or an 'opaque gravy train to the DH'⁽¹²¹⁾.

'*Liberating the NHS - Developing the Healthcare Workforce*⁽¹²²⁾ regards healthcare providers as the engine of the new system as they take on existing SHA workforce functions. According to Andrew Lansley,

'Following the reforms outlined in the White Paper "Equity and Excellence: Liberating the NHS", we want to empower healthcare providers, with clinical and professional leadership, to plan and develop their own workforce. They know what services their patients and local communities require – and they know what staff they need to deliver excellent, responsive healthcare. Therefore they are best placed to commission the education and training that will achieve the right workforce'. (p. 3).

The document contains more criticism of 'top down' approaches (e.g. pp 6-7) and proposes 'increased autonomy and accountability for healthcare providers'. The document proposes the creation of an autonomous statutory board to support healthcare providers in their workforce planning, education and training, Health Education England (HEE), which will be a lean and expert organisation, free from day-to-day political interference, focusing on workforce issues that need to be managed nationally. However, despite sections such as 'Planning and Developing the Whole Workforce' (p. 20) the document appears to be remarkably focused on the clinical workforce. Similarly, although it does contain the word 'talent', there is no mention of TM. There is a brief discussion of leadership. 'A consultation into the future design of the education and training system for undergraduate and postgraduate professionals in healthcare would not be complete without consideration of how leadership and management development will be commissioned. The White Paper *Equity and Excellence: Liberating the NHS*⁽¹¹²⁾ makes it clear that clinicians will be in the driving seat and this must be reflected in the education and training system so that current and future clinicians are equipped to be professionals, partners *and* leaders. Moreover, it continues that the NLC has led the drive over recent months to partner with professional bodies and higher education to ensure that leadership development in health is incorporated into undergraduate and postgraduate curricula. There has also been investment provided to broaden the experience of a whole new cadre of clinical leaders through the clinical fellowship programme. There is much still left to do, however, and it is proposed that HEE be accountable for the framework of leadership development across all leaders in healthcare, including those with clinical training and those without. HEE would thereby contribute to developing leadership capabilities that foster trust across clinicians and managers who have too often been developed within silos. As Imison et al⁽¹⁰⁰⁾ point out, despite the vision of a provider-led workforce planning:

'in reality, no workforce planning system that is underpinned by central funding for commissioning and in which an organisation the size of the NHS is the major employer can ever be solely local in workforce planning.' (p. 20)

The details of the new workforce system are still 'work in progress'. David Nicholson sent out a 'Dear Colleague' letter in February 2011 in which he set out four principles of change that underpinned the 'Inspiring Leaders' document⁽¹⁰⁸⁾: co-production, subsidiarity, clinical leadership and alignment. It also contains a timetable for changes (Annex A). On 6 April, the Government announced that it would take advantage of a natural break in the legislative timetable to "pause, listen and reflect" on modernisation plans and bring about improvements to the Health and Social Care Bill where necessary. An eight week NHS Listening Exercise was announced, with four main themes: choice and competition; clinical advice and leadership; patient involvement and public accountability; and education and training. The NHS Future Forum⁽¹²³⁾ set up four groups to examine these themes which fed into the main report.

The overarching recommendation of the Clinical Advice and Leadership Group⁽¹²⁴⁾ was that multi-professional advice and leadership should be visibly strengthened at all levels in the system. It suggests that there should be clinical advice and leadership at all levels of the system and clinicians should be supported through leadership development. The National Quality Board should review the provision of CPD across the NHS. All NHS organisations, particularly new ones, should ensure that appropriate leadership development and support are in place. The group heard the view that the NHS has not taken CPD for its staff seriously. People reported that there was huge variation in the support for CPD within and between organisations and across the NHS. It also heard some concerns about whether the diversity of clinical leaders reflects the makeup of the current and future clinical workforce. It stated that the variation in the current provision of CPD for NHS staff is unacceptable. It continued that the NHS Constitution commits the NHS to provide staff with personal development and appropriate training. This commitment should be honoured and CPD should be prioritised and accessible to all staff in an appropriate and proportionate way. Development should be part of appraisals and linked to the outcomes that organisations are working to achieve.

The Education and Training Group⁽¹²⁵⁾ pointed to the unclear transition arrangements associated with the abolition of SHAs. It emphasised that most of the future workforce of the NHS is the current workforce. To deliver the NHS of the future requires all staff, not just professional staff, to have access to CPD. The group heard of examples of where CPD was undertaken comprehensively but also heard from staff who had received no professional development since qualifying. It supported the recommendation of the Clinical Advice and Leadership Group in relation to CPD.

According to the main report of the NHS Future Forum⁽¹²³⁾, education and training of the healthcare workforce is the foundation on which the NHS is built and the single most important thing in raising standards of care. More time is needed to get this right as the effects of mistakes made now will be felt for a generation. The ultimate aim should be to have a multi-disciplinary and inter-professional system driven by employers. The roles of the postgraduate medical deaneries must be preserved and an interim home within the NHS found urgently.

It was noted that the Education and Training workstream was unusual in that it was not included in the Bill. The NHS Listening Exercise came on the heels of a three month consultation on the Government's White Paper "Liberating the NHS: *Developing the healthcare workforce*."⁽¹²⁶⁾ Changes had been proposed to the arrangements for education and training commissioning as a consequence of the proposed abolition of SHAs.

The report recommended that the proposed Health Education England, which has been almost universally welcomed, needs to be operational as soon as possible to provide focus and leadership while the rest of the education and training architecture is planned. Where plans for the new local education and training boards cannot be in place by the time the SHAs are abolished, the workforce functions related to educational commissioning and workforce planning and the post graduate medical deaneries should be transferred to a host organisation within the NHS family until the new organisation is functioning.

In August the government reported the summary of consultation to its workforce plans⁽¹²⁶⁾ It stated that the broad principles such as responsibility of employing organisations; multi-professional training were welcomed. The responses suggested that it would be important to embed leadership into all levels of training and development and that opportunities should be available to acquire and develop these skills in the work place. Leadership and management functions should be accompanied by a requirement to demonstrate that they make a difference, they must be coupled with good staff appraisals and CPD. It was also suggested that it would be important to build on the existing body of good practice, for example the work of the NLC and NHS Institute. Some respondents suggested utilising the NHS Leadership Framework and referenced the work coming on-stream from the Faculty of Leadership and Management. A significant proportion of respondents agreed with the proposal that Health Education England should have responsibilities for the leadership development framework for managers as well as clinicians.

However, none of these education and training documents discussed TM *per se*, and education and training is one element- albeit a very important one- of TM. They all appeared to focus largely on clinical education and training, and stress was placed on organisations such as the Centre for Workforce Intelligence (CfWI) that does not appear to have any responsibility for TM. Meanwhile, commentators point to a 'brain drain' as many senior staff leave PCTs.⁽¹²⁷⁾ A 'HSJ' survey of Freedom of Information (FOI) responses from 57 PCTs revealed that 35% had more than 15 years experience in the NHS; 21% were band 8 or above; 21% were clinicians; and 17% were in commissioning roles. However, these departures have not freed up as much cash to pay for clinical commissioning groups as had been hoped.

3.4 Conclusion

Managing talent (mt) has a long history in the NHS, and the current 'Talent Management' (TM) approach arguably introduced little that was completely novel. However, the new approach aims to mould the individual elements into a more coherent and cohesive system, but a combination of financial austerity, a producer-led approach, a focus on 'workforce planning' that appears to exclude TM and a focus on clinical education together appear to marginalise TM. The issue of how much of the post-2004 TM system will remain in the new system architecture is far from clear.

4 Focus Groups

4.1 Introduction

Focus groups are a form of group interviewing that stresses the interaction within the group based on topics that are supplied by the researcher.^{(128); (129); (130)} As participants query each other and explain themselves to each other; synergy and interaction effects offer valuable data on the extent of consensus and diversity among the participants. The researcher can draw upon respondents' attitudes, feelings, beliefs, experiences and reactions in a way in which would not be feasible using other methods, for example observation, one-to-one interviewing, or questionnaire surveys. Compared to observation, a focus group enables the researcher to gain a larger amount of information in a shorter period of time.

There are some differences between commentators regarding the size and composition of focus groups. The generally suggested size is about six to ten people per group, but some researchers have used up to fifteen people or as few as four. Both homogenous and heterogeneous groups have been suggested, depending on research design. While some researchers recommend aiming for homogeneity within each group in order to capitalise on people's shared experiences, others point to the advantages of bringing together a diverse group to maximise exploration of different perspectives within a group setting. Although it may be possible to work with a representative sample of a small population, most focus group studies use a theoretical sampling model whereby participants are selected to reflect a range of the total study population or to test particular hypotheses. It has been suggested that focus groups are suitable for examining how knowledge, and more importantly, ideas, develop and operate within a given cultural context, and that they are an effective technique for exploring the attitudes and needs of staff, and are useful for studying dominant cultural values and for examining work place cultures.

We held two sets of two Focus Groups. The first set was held in late 2009 to validate findings emerging from the Exworthy and MacFarlane Nuffield study⁽⁹⁴⁾ and from the literature review, and to pilot our interview schedule and questionnaire survey.

The second set was held in late 2010 to examine preliminary findings from the study, and to note how they resonated with, and were interesting to, NHS managers. These groups also recognised the shift in context and took the opportunity to discuss TM in a potentially 'cold' climate.

4.2 Method

The Focus Groups were held at University Hospital North Staffordshire NHS Trust. One of the project team had a good and longstanding relationship with the Trust, and we were pleased not only to use their 'good offices' for this phase of the research, but the Trust also agreed to act as the lead NHS Research and Development (R&D) contact for the research for the purposes of our NHS ethics application. Each focus group session was attended by two members of the project team, and all group discussions within each session were recorded and subsequently transcribed for analysis.

Our liaison at the Trust invited 40 managers selected at random from NHS organisations in the area on behalf of the project team. They were provided with a summary of the project, a participant information sheet and specific details about this stage of the project and what would be expected of them. Project Consent Forms were completed on the day at each of the sessions. (Appendix 1)

The first set of focus groups involved three tasks for participants:

- 1) 'mapping' out their career journey's on A3 sheets and discussing them in group;
- 2) review and discussion of the key points identified in our literature review. Each theme was typed onto an A4 sheet, and respondents were asked to review each theme and indicate their initial responses on 'sticky's' which they attached to the sheets. Discussion then took place in group;
- 3) review and discussion of the draft interview schedule to be used in our cohort interviews. Hard copies of the draft schedule were circulated and respondents were asked to comment on any issues they found, including identifying:
 - i) any questions they would struggle to answer;
 - ii) which questions, if any, did not apply to them;
 - iii) which questions would be most useful to the NHS;
 - iv) any additional questions that could usefully be asked.

The second set of focus groups included two main tasks:

- 1) review and discussion of the preliminary findings from the research. The main themes were distributed amongst the group on A5 cards, with the cardholder initiating discussion on the particular theme;

- 2) a review and discussion of issues around 'changes over time' which included discussion on:
- i) TM in a 'cold economic climate';
 - ii) TM in a 'cold organisational climate'; and
 - iii) whether TM has been effective for both the individual manager and the organisation.

We aimed to achieve heterogeneous focus groups in terms of gender, experience and employer. Analysing focus groups is basically the same as analysing any other qualitative self report data, but it is necessary to draw together and compare discussions of similar themes and examine how these relate to the variables within the sample population, and to try to distinguish between individual opinions expressed in spite of the group from the actual group consensus. As in all qualitative analysis, deviant case analysis is important: attention must be given to minority opinions and examples that do not fit with the researcher's overall theory. The only distinct feature of working with focus group data is the need to indicate the impact of the group dynamic and analyse the sessions in ways that take full advantage of the interaction between research participants.

All audio transcripts, written responses and the career maps were reviewed independently by two members of the project team, to identify the main themes that are presented in the analysis that follows.

4.2.1.1 Limitations of Focus Group Method

It has been pointed out that the effect of the moderator can be very important, but that s/he has less control over the data produced than in either quantitative studies or one-to-one interviewing. It should not be assumed that the individuals in a focus group are expressing their own definitive individual view. They are speaking in a specific context, within a specific culture, and so sometimes it may be difficult for the researcher to clearly identify an individual message. The downside of such group dynamics is that the articulation of group norms may silence individual voices of dissent. However, we found largely homogeneous views and few, if any, individual voices of dissent. Perhaps the major problem with all the methods employed in this study was with their link with theory, as Chapter 2 indicated that TM remains under-developed in theoretical terms.

4.3 First Phase Focus Groups

4.3.1.1 Reflections on NHS careers

Thirteen managers attended the first Focus Group sessions: seven women and six men. Participants were currently employed by provider organisations in mental health, community based services and ambulance services, and from commissioning organisations and the SHA. Their career spans were between four and thirty-eight years and current roles reflected a spectrum of NHS positions both clinical and non-clinical.

The participants were first asked to draw out their career journeys as a 'map'. Nine of the thirteen participants had spent all their working lives in the SHA region, although not necessarily employed by the NHS. The fewest number of job changes was four, and the highest was twelve, and two people had worked in other countries. The length of time in each job role varied but it was rarely greater than four years. Eight people had begun their working lives in the NHS; two as graduate management trainees, four in clinical roles; two in administrative roles. Three had first jobs in industry, although in two cases this had been for less than three years, and the remaining two in other public sector organisations.

Only one person expressed a life-long desire to work in the NHS:

"I knew I wanted to be a paramedic from a little boy that was it. I was one of those that was always pointing to an ambulance as it drove past and I knew that was it the ambulance service."

All of the participants noted that they had personally made one or more deliberate and fundamental decision about their own career. Some more general decisions about life had also greatly affected careers, including finding a 'better' job, career breaks to have children, and changing jobs to fit in with a partner's career. However, there were also many examples of career moves being taken because of unplanned events, 'serendipity' or 'falling' into a post 'by accident'.

Career moves had not always been through a straight forward route of application and acceptance. Four individuals had taken at least one secondment to help them to either get promotion or move into a new field. In each case the secondment had resulted in a new post within a year; although not always at the seconded role. Another four individuals noted 'acting' posts within their career map, and again that period acting into a post had resulted in an ultimate move:

"It is quite interesting to think about how many of these jobs have been fixed term secondments or short term contracts to have then turned into more permanent posts. When I reflect on it since 1982 every job I have taken started off as something part time secondment and not permanent."

In both groups discussions about secondments were very positive and clearly noted as one effective way to grow in one's career.

However, it is interesting to note that people found it difficult when they were in another part of the picture – when they applied for a permanent post that appeared to be already 'filled':

" I get quite frustrated and I don't know if it's like this in other areas of the NHS where a job is advertised and you can sort of put a name to that job before you have even had your interview. I find that very very frustrating."

Eleven individuals had taken some form of additional study that was associated with their career. Two had been part of the General Management Training Scheme; three others had completed Masters level degrees, one studying for some parts of the degree whilst on maternity leave. Three people had followed some form of additional qualification whilst in post (all clinical) and one had also completed an internally led accredited management development programme. One person had studied to post graduate level before joining the NHS. However discussion in the first focus group demonstrated some dismay at the current attention given to the requirement for academic qualifications:

"They are looking for masters degrees in everything but when you are in the position that most of us are when you first join the NHS well over 15 years ago or more, you didn't have the opportunity to go to University then because you didn't have to go to university to be a paramedic .., so if I want to be a director ... I haven't got a masters degree."

In drawing out the career maps people were asked to think about enablers and barriers to progression. Several people commented on supportive managers who had helped them throughout their career – and on organisational changes or systems that had proved to be barriers. Only one person noted a specific organisation based block to their career, an 'unmistakeable glass ceiling' in that organisation and that she had had to move out to be able to continue to further her career. However the notion of a block could be positively challenging and supportive to progression:

"You can either decide to use that or not, either stick it out or decide to do something."

"If you have a manager who is not supportive and not good that might be a push factor."

The issue of whether the NHS values its managers prompted a range of strong views. Some felt that managers are not valued at all:

"I don't believe the NHS value talent in any way shape or form. You feel as a manager as a leader you are punished."

"I wouldn't advise anybody joining the NHS, seriously, I think we are totally undervalued, under appreciated, sometimes by the public, sometimes by the organizational leads."

"I am absolutely mortified by the amount of harassment and bullying that goes on at that high level."

However others felt that this was what one would find at a senior level in any industry and that often individuals were valued at organizational level by their line manager. Some noted managers were less valued by the public than clinicians, and some who were clinically trained stated that they use their clinical role to describe what they do:

"The public still see the NHS as doctors and nurses don't they, and they value the professions whereas you know we go out sometimes and say I work in the NHS as a manager, and you don't get an awful lot of recognition and value for the contribution that you make."

Putting all these perspectives together, there were some different views on whether the NHS was an employer worthy of recommendation:

"I really enjoyed working for the NHS, I have been very fortunate with the people I have worked with and listening to friends who work in other organizations they are not being supported as I have."

"I think you have to love the NHS, if people do things to the NHS that you don't agree with then you have to change, and therefore if you work for the NHS it is going to be a bumpy ride, and so if you don't love the NHS you probably end up getting out."

During the sharing and discussion of career maps some of the core issues from the literature can be observed, in particular the use of techniques such as secondments to manage talent, the importance participants gave to needing to feel valued and supported, and the roles and responsibilities taken by individuals, their managers and others within the system. Most important, however, is the range of reflections and experiences collected from a small number of individuals who all now work for the NHS. However, there is little sense of any systematic approach to managing their development and deployment.

The participants in the focus groups were also shown a set of statements that summarised the key points from the literature review and asked to note their reactions to each of these statements. All of the core questions and dilemmas that were identified in the literature resonated with issues that they thought were important within the NHS.

There was some confusion over the phrase TM:

"Are we suggesting from the phrase talent management that managers have got flair or a talent for managing?"

Most were able to provide individual definitions but were unfamiliar with its use in the NHS:

"For me it is nurturing those individuals of organization with potential for further development and making progress and actually identifying and capturing that and how to then help and support (them) as they progress."

Opinions were divided as to how well the NHS currently identifies, supports and retains talented people, and it was noticeable that generally those who were more positive in their views came from certain organisations and were in roles with responsibility for development.

Several were uncomfortable with the notion of focussing on talented individuals, mentioning possible resentment and reduced respect from others:

"Depends how it is handle, could be welcomed if the whole organisation embraces it."

And noting that there are dangers in the NHS, dangers which suggest a leaning to a soft HRM approach; for instance the problem that arises when managers don't fulfil expectations:

"A major challenge and often fudged. In the past I have seen big pay offs rewarding people through redundancy packages to remove people who have been rewarded beyond ability."

4.4 Second Set of Focus Groups

Two further focus groups were held in late November and early December 2010 to provide a discussion forum that would consider key themes that had been collected from the cohort interviews. The 11 participants in those groups came from a range of NHS organisations including PCT, Acute Trust, Ambulance Trust and Mental Health Trust. Their professional backgrounds were diverse, including finance, nursing, organisational development, training, pharmacy, general management and information management. They were presented with summary statement of the themes and asked for their reactions.

None of the themes brought out any strong disagreements, either with the material that had been summarised from the interviews, nor in discussion with each other.

The year between the two focus groups may have seen some shift in thinking in middle to senior managers in the NHS. While few in the first set of focus groups had heard of TM as a formal process within the NHS, participants in the second set were more comfortable with the term and its application. People were readily able to provide their own definitions, most of which includes the core notion of development within an organisational framework:

"Talent management is about there being a bigger plan somewhere ... I can manage my own ability and I go for development but to me for talent management to have a place there needs to be some sort of pyramid of it fits into a bigger system."

"For me, you know, it's about matching ability with ambition, it's about people achieving their potential and what's the support they need to be able to do that."

It was pointed out that the NHS has long had a focus on people development; continuing professional development (CPD), lifelong learning and training were all mentioned as processes and phrases used in the past, participants generally considered that the way in which managerial talent

was now being identified and encouraged (the TM system) was an improvement:

"Because definitely again until the last two years, all the support has been fantastic but it's been kind of unstructured, so it's been a 'there's a need to do this, do you want to give it a go?' rather than 'actually, we need to get you on some formal training and we need to get you some formal coaching.'"

"I've been in the NHS twenty five, thirty years and that's the first time it's been that structured and objective, in my personal experience."

However, there was some disquiet at the use of the term 'talent', with unfortunate resonances of ideas about celebrity and 'rising star', and thoughts that TM may only apply at certain senior levels:

"Talent management for me is about maximising the potential of every member of staff, ... but the focus, you know, does tend to be around leadership."

"I can see that in my organisation but that seems to be where we've got the talented graduates coming through, you've got your aspiring chief execs but you could get lost in the middle and that's where you want to actually see your talent isn't it?"

In response to a question about ownership of TM, most agreed that all parts of the NHS system have some responsibility for TM, and that the important issue is to have clarity on who is doing what. However, there were some issues around the extent to which the NHS was one system and could therefore replicate the way in which a private company might manage its workforce talent:

"A lot of the NHS organisations are fairly independent and operate as individual functions, whether it's PCTs, acute trusts, ambulance trusts, and we all have different ways of doing it at the moment. And then trying to move that to a position where everybody does it the same way and in terms of talent management, organisational boundaries don't exist effectively is what we're saying. That would be, I think, a big move because at the moment it's a case of 'well that's my employee, they're on my books and actually I will hold onto them because they're good and I will try and move them up through my organisation rather than risk losing them to another trust or another PCT.'"

"It's not a kind of standard approach across all our organisations and it's not that there's a big meeting to discuss who are our future leaders and from that pool that they've got a register It's usually there's a new course with the SHA, we need two names, who would like to do it. Or, other reasons help form that decision making. It isn't necessarily in a very planned way as part of the internal CPD process."

And some disbelief that any system can be objective, being necessarily variable as it still relies on individual 'talent spotting':

"It's got to be your manager and you."

"It's too impersonal at any other level in the organisation."

Without a transparent approach to talent spotting and resulting selection on to programmes there will remain a perception of some sense of favouritism and that s/he who pushes themselves forward may be given more opportunities:

"I suppose there's a danger then that people who are aggressive in their career will keep moving whether they're any good or not and it's how you actually spot the really talented people that you want to be moving through."

"And maybe those people have been chosen because they have the skills for how things are going to progress in the future, you know, and being strong-willed, strong-minded and very vocal is perhaps a very good chance."

A number of the participants in the focus groups had been participants on SHA organised programmes, others on more local programmes. All who had been involved with such development reported their personal satisfaction with the experience but there was a sense of 'credentialism' and unclear expectations for organisations and for individuals who might 'aspire' but have few posts to aspire to:

"I think it's also that some of these things get seen as the gateway to the next level. Like you can't become a director unless you've done the aspiring directors course, or if you've done it, regardless of how good you are, does that get you a step up the ladder closer to that than somebody who hasn't done it who might well be a better potential director."

"So my organisation puts me on, what does the SHA expect of my organisation? What does my organisation expect? So that was great for me as an individual but it didn't seem to link into what my organisation might view or what the SHA might view."

"[For people who have completed 'Aspirant' courses] I have to die or retire so where does she go?"

It was also stressed that TM is not just about spotting talented people and putting them on to programmes, but using existing talents and sharing skills, and making sure people are up to the job when they come into post:

"... some of it perhaps isn't about development and courses, it's about using the talents that we've got in the organisations so placing those talents or, you know, how do you share that skill that you've got with someone who's doing something totally different in perhaps a different organisation rather than actually having to gain new skills but actually use the power that we actually already have."

Fairness and transparency were regarded as major concerns:

"It's the conflict between that approach to talent management and this fairness approach about advertising because I bet there isn't one person round the table who hasn't experienced the, well, 'my job's been advertised'. So then the other side of it is we have spent a lot of time developing that talent and we have got some people who are ready for it and [why bother] putting it out in a national newspaper and how do we balance all of that?"

"There's a perception of jobs for the boys isn't there?"

Participants wanted a system that supported everyone, and clearly gave a nudge to those who are able but less inclined or able to be self managing:

"At some levels some staff just don't have the confidence to say 'well actually I'd like to do this course'. You have to almost encourage them and draw it out."

"Everybody should have an equal opportunity to that type of patronage I think and I think the NHS doesn't do a good job of it at the moment. It doesn't coach well, it doesn't mentor well and if you

look at those skills in industry they are what help develop our talents."

It was also reinforced that TM needs to be about managing those people who are not talented:

"We haven't got systems like a private company would have to like move people if they're not performing. So I'm using the word 'untalented' loosely, you know, but in this context there have become for whatever reason cultural changes, different focus, they would become like they don't fit anymore but we don't deal with that because we don't allow ourselves."

The discussions on diversity concluded that the SHA and local organisations had introduced several programmes and interventions to improve the proportion of BME managers in the system and support employees from BME backgrounds. Indeed, some participants had experienced work in an NHS Trust that had set up preferential routes:

"...was the opposite, it almost felt that there was a route in through there for people of a BME background and it put us at a disadvantage who aren't of a BME background. So I think it is about a balance."

"I think we are, hopefully, I personally feel that we promote opportunity in the workforce based on talent, you know, and that is irrelevant of where that individual's cultural background is and should be based on their skills and their competencies and their opportunity for development that they demonstrate."

Participants pointed to a very different and often neglected sense of diversity in a very different sense – 'mavericks' who think and possibly behave differently from others, and who will challenge the system. Some commentators such as Page⁽³⁴⁾ consider that 'cognitive diversity' (thinking differently) is more useful than 'identity diversity' (gender, race):

"Your talent spotting processes can be quite subjective because you might be somebody who seems a bit of a maverick because of the organisational culture."

"If your face doesn't fit often you're not spotted, then you're ignored or sidelined and often if your face doesn't fit it's because you've challenged the status quo or you're different or you create some novel opportunities that people find very difficult to understand. And yet they're the people we need. So for me,

diversity is about taking risks with who we recruit and who we develop and really develop those people who challenge the status quo."

Finally, participants were asked what they felt were the implications of the tight resources and a fundamental shift in NHS responsibilities and structure, which may lead to TM in a Cold Climate. While they were unanimous in saying that it is in these times that TM becomes even more important, they considered that there would be some clear cuts in budget meaning that 'SHA programmes will go', but some organisations may prioritise TM:

"And you need your talent when it's crucial, when you've got your back against the wall. That's when you really need the people who can deliver for you. But I think a counter argument to that, you know, when we're in a situation now where we're having to be financially accountable, you know, you do look at what you can cut, what you can't cut and the main stay of that is quality and patient safety and one of the first things to be considered is education, it's development and do we do that, don't we do that? But I think that's the most crucial time when absolutely you hang onto that."

"Our organisation is definitely (keeping a focus on TM), and it's from the chief exec and the senior team, it's about making sure that we keep the good people in the NHS. That's their motto almost."

With a possibility of less movement and fewer promotion opportunities, TM may need to change its focus more to motivation and development in situ. It may be that the changes provide an opportunity to ensure that organisations retain the very best people, develop new skills and insist on high standards of performance:

"I think it's different. I mean I think there are still the opportunities to do more of the seconding, shadowing, you know, they're certainly looking at how to use the people we've got within clinical practice who are educators in a more effective way so that we can sort of teach in-house and use their skills so I think there are going to be opportunities but I don't know about progression. I think it will be a lot more challenging to try and get promoted because there's not going to be as many of those types of jobs around for a time."

"Because the danger is that, you know, in the absence of talent management or any kind of support that their motivation goes through the floor because everything is difficult and people can't see

beyond that threat from the organisation. It's still about trying to get the best out of your people and getting the right people in the right posts. However that is done, with a talent management programme, is the best chance of being able to do that."

"I think it's a buyer's market at the moment and I think that's a terrible term but the reality is that that's where we're at and we're in the very fortunate position to cherry pick individuals who we want in the organisation and we can apply internal pressures to make sure that people are performing better but we're a bit slow in making sure the systems and the policies and procedures that we need to help us achieve that match what the requirements are."

"I think in a cold climate it might be – I'm not say it is – but it might be that you need to develop people who have a different range of knowledge skills and attitudes in order to lead their organisations in different ways."

Some participants considered that TM must adapt to these 'new times' with and a whole system development programme:

"And I think part of the thing about TM, it is keeping it flexible and fluid enough to cope with the constant restructuring which happens in the NHS. Because with the best will in the world, you know, today's structure we all know will not be the same as the structure in twelve months, two years time."

"I think it's a really good point. If you get talent management right what we get is agile organisations that are able to adapt very quickly to circumstances so we don't get this lag of well, we've got this new threat or opportunity, whatever it might, it takes a while for the skill set or the staff to catch up whereas if you get talent management right, the skill set's already there and it switches very quickly into the new mode of working."

"If talent management nurturing for want of a better word is within one organisation, you're limiting everything. Whereas if it was something that was signed up to across multiple organisations so that you had your talent pool for whatever you want to call it and the organisations worked together, you are minimising the risk. And you're also optimising the opportunity to move specific people because they've got a specific set of skills into an organisation that

at that point really needs somebody with that strength to perhaps do some turnaround stuff, do you know what I mean?"

4.5 Conclusion

Participation in all groups was voluntary and it is accepted that there would be some notion of self selection leading to a bias in levels of interest. However, there was a degree of wariness and cynicism about TM in the NHS throughout the focus meetings, suggesting that the conclusions reached may well be replicated across the majority of middle and senior level NHS managers.

Talent management may well be a phrase that is increasingly recognised but there is no universal definition and no recognised 'felt fair' process in the NHS.

Several tensions were expressed in the discussions:

- Agreeing a systematic and objective process that can be flexible
- Individual desire to be recognised and supported balanced against the discomfort of being one of the chosen
- Local vs national perspectives- how to hold onto organisational talent whilst understanding the benefits of a national system
- Providing developmental programmes but ensuring they are not a tick box to promotion
- Encouraging support and mentorship whilst ensuring transparency
- In a cold climate – tightly managing resources and ensuring development.

5 Documentary Analysis

5.1 Introduction

This chapter compares the national DH guidance to SHAs on TM and leadership⁽¹⁰⁸⁾ with the SHA Talent and Leadership Plans (T&LP). The Talent and Leadership plans from each of the 10 SHAs in England were obtained either from the relevant SHA website or through a direct request to the SHA lead on talent management and leadership that was interviewed (see Chapter 6). Recent SHA Assurance Panel Reports have been published on the DH website for four of the SHAs: South West; South East Coast; North West; East of England. The recent change of government, however, has seen this information source 'archived' (dated: 06/05/2010) and no further panel reports added.⁽¹³¹⁾ The panel report for NHS London was obtained directly from the SHAs website. These five SHA Assurance Panel Reports were available at the time of writing this report.

In 2009 the DH published 'Inspiring Leaders'⁽¹⁰⁸⁾. In his 'Foreword', David Nicholson set out four principles (p. 5):

1. co-production (all parts of the system working together);
2. subsidiarity (ensuring that decisions are made at the right level of the system - as close to the patient as possible);
3. clinical ownership and leadership (clinicians on board); and
4. system alignment (the different parts of the system pulling in the same direction).

In accordance with the principle of subsidiarity, the [Pyramid] diagram sets out the key role and responsibilities for talent and leadership development at each level of the healthcare system (national, regional, employer, individual) (p. 7).

The guidance has been shaped by four SHA health economies, and a diverse range of local employers, with the detail reflecting the learning from those involved in designing and testing the guidance. It can be built on so that it meets regional needs (p. 16). It set out the following key content areas (p. 17):

- vision and behaviour required to transform leadership for quality ;
- methods- diagnosis;
- plans to close the gaps;

- pathways and investment;
- links to system-wide initiatives; and
- barriers and risk.

The guidance is fairly 'light touch' with few mandatory elements, and sets out a number of questions that SHAs 'may want to consider'.

The guidance stated that prime responsibility for improving talent and leadership clearly rests with local employers. SHA Boards will ensure that a completed T&LP is in place by the end of July 2009. T&LP will form part of the SHA assurance process. Initially the prime focus will be on Aspiring CE and Aspiring Directors (AD). However, in the longer term, it is anticipated that the five-year outcomes for SHAs will include:

- ensuring a systematic approach is in place;
- increased leadership supply, including clinical leaders;
- with leaders reflecting the workforce and the communities they serve (particularly BME, women and disabled people). (pp. 11-13)

Measures to ensure readiness for T&LP will include:

- the SHA chair and CE personally and demonstrably lead the improvement of leadership capacity and capability both within the SHA and across the regional system, and this is likely to be more than 20% of CE time;
- there is a named SHA Board director who leads on improvement of leaders;
- action plans in place that are consistent with the four principles;
- the plans will address the necessary infrastructure, culture and data for collaboratively delivering sustainable improvement;
- the SHA board can demonstrate that it is satisfied with how they will improve the TL dashboard measures, particularly for clinicians, those from BME backgrounds, women and disabled people (p. 15).

5.2 SHA Talent and Leadership Plans

Although many of the SHA T&LPs broadly followed the 'Inspiring Leaders' framework, they came in various shapes and sizes, with differing contents, some of the 'givens' were not fully clear, and it was difficult to collate the data into a clear template.

As Table 1 shows, the length of the SHA documents varied significantly. The key content areas of DH guidance⁽¹⁰⁸⁾ were broadly followed in most SHA

documents, with a few minor exceptions. For example, 'Diagnosis' was found mainly in an Appendix in two SHAs, while a further two focused on 'capacities and capabilities'. Some of the plans focused on risks only rather

Table 1. Broad content of Talent Management and Leadership Plans

	Vision	Diagnosis	Plans/ Closing Gaps	Pathways	Links	Barriers
EE (34pp)	N?	Appendix	Y	Y	Developing PCT	N?
EM (60pp)	Y	Appendix	Y	Y	Y	Y
L (38 pp)	Y	Y	Y	Y	Y	Y
NE (32pp)	Y	C+C	Y	Y	Y	N?
NW (45pp)					Y	
SC (42pp)	Y	Y	Y	Y	Y	Y
SEC (29pp)	Y	C+C	Y	N	N	Risks
SW (38 pp + Appendices)	Y	Y	Y	Y	Y	Y
WM (37pp)	Y	Y	Y	Y	Y	Y
YH (40 pp + 18pp Appendices)	Y	Y	Y			

Key: Y = yes; N = no; C+C = capacity and capabilities

EE = NHS East of England⁽¹³²⁾; EM = NHS East Midlands⁽¹³³⁾; L = NHS London⁽¹³⁴⁾; NE = NHS North East⁽¹³⁵⁾;

NW = NHS North West⁽¹³⁶⁾; SC = NHS South Central⁽¹³⁷⁾; SEC = NHS South East Coast⁽¹³⁸⁾; SW = NHS South West⁽¹³⁹⁾;

WM = NHS West Midlands⁽¹⁴⁰⁾; YH = NHS Yorkshire and the Humber⁽¹⁴¹⁾.

than 'barriers and risks'. The North West⁽¹³⁶⁾ tended to present a rather different approach, with its content based on:

- the NW vision;
- national principles in the NW context;
- challenges;
- NW insights;
- where are we now?;
- current TM metrics;
- Assurance; and
- Links and Alliances.

Table 2 examines the extent to which the more detailed content from the DH guidance⁽¹⁰⁸⁾ was followed in the SHA Plans. Relatively few SHAs set out and discussed the 'Pyramid' diagram and the four principles. While most set out the 'Dashboard' data, some of this was set out in different ways (below) and none explicitly stated that the SHA and Trust CE would spend 20% of their time in developing talent, and gave the named Director for TM. Some SHAs presented their own models, while there some, but not all, went down the 'Academy' route.

Most of the SHAs claimed to follow the national guidance, but adapt it to local circumstances. For example, London SHA⁽¹³⁴⁾ outlined the '*unique workforce challenges and complexities facing the NHS in the capital*', but stated that its four key areas of focus over next 3-5 years were '*fully aligned with the Department's vision set out in Inspiring Leaders*' (pp. 3, 5). The EoE Leadership Institute will deliver innovative approaches to suit local context⁽¹³²⁾.

Some claimed to be leaders. For example, the West Midlands⁽¹⁴⁰⁾ led the way nationally in being the first SHA to deliver a development programme for Aspiring Chief Executives (ACE) (p. 16). The East of England⁽¹³²⁾ claimed that '*we have a good track record in the east of England. We are 'ahead of the game' with requirements of DH guidance.*' (p. i). It is the first SHA that has delivered a systematic approach to TM and rolled it out to all PCTs across the health system. The West Midlands stated that their SHA contained two members and two Fellows of the NLC.⁽¹⁴⁰⁾ (p. 7). Five NLC members are senior leaders from EM, two of whom lead individual workstreams⁽¹³³⁾ (p.13). The four SHAs stated that they participated in the leadership proof of concept project ⁽¹³²⁾ (p. 1); ⁽¹³³⁾ (p. 7); ⁽¹³⁸⁾ (p. 10); ⁽¹⁴⁰⁾.

Table 2. Detailed content of Talent Management and Leadership Plans

	Pyramid	Four Principles	Models	Academy	Readiness: 20%; named Director.	Dashboard measures: clinicians, BME, women, disabled people
EE	Y	N	Essentials; Talent Map; Progression.	N	N	Y
EM	N	N	Identifying; Tracking; Positioning; Developing; Retaining Talent.	Y	N?	Y
L	N	N	?	Y Leading for Health Foundation	N	Y
NE	Y	N	Integrated model for talent management	Y	N	Y
NW	Y	Y	Leadership journey cycle; PDSA diagram.	Y	N	Y
SC	N	N	-		N	Data?
SEC	N	N	-	N	N	Y
SW	N?	N?	Five frames		N?	Y
WM	N	N	-	N	N	Y
YH	Y	N	-	N	N	Y

5.3 Vision and Behaviour for Change

According to the DH guidance⁽¹⁰⁸⁾, vision for talent and leadership for quality is that we are: spoilt for choice where everyone counts and we are as focused on our leadership development as on our clinical outcomes and financial management so that we provide better patient outcomes and ever increasing public confidence (p. 10). The plan should set out a 3-5 year vision, and obligations laid out in the NHS Constitution need to be addressed (p. 18). It is stated that behaviour change may be required to develop a culture which fosters leadership development for quality. Earlier work with four SHAs identified five areas where behaviour change may be needed: taking succession seriously; creating consistency and transparency of process; demonstrating boldness and openness; willingness to steward talent across the system; valuing diversity across the system (i.e. represents workforce) (p. 27).

According to the DH guidance⁽¹⁰⁸⁾, 'vision and behaviour' identifies the SHA vision and summarises what will be different about talent and leadership capacity and capability in three/five years' time and the accountabilities and behaviour that will underpin success. (p.17) The document continues that in order to create the right conditions for improvement, we anticipate that SHAs will not only describe 'how' talent and leadership plans will be produced, but also the cultural change required to enable the necessary collaboration between organisations. (p. 16)

Most regional visions heavily reflected the national vision. Some referred to background material such as Darzi^{(106); (107)} the 2008/9 Operating Framework⁽¹⁰⁵⁾. The East of England⁽¹³²⁾ stresses 'priority actions' rather than a vision (p. 12). The East Midlands⁽¹³³⁾ states developing leaders has been identified as one of our nine 'big ticket' issues, with work programme (p. 11). 'What success will look like' includes:

'when we have a culture where talent and leadership is seen as core business. Senior leaders take a proactive and strategic approach, and dedicate quality time to developing their successors.' (p. 14)

It is claimed that leadership development in the workplace will be treated as mainstream business and prioritised by every NHS Board and be a personal objective of the Chair and CE (p. 16). London⁽¹³⁴⁾ sets out a broader, as opposed to a TM and Leadership vision, in the context of the '*unique workforce challenges and complexities facing the NHS in the capital*'. London's unique challenges include population, and a complex healthcare system. (p. 3). The key objectives for the North East⁽¹³⁵⁾ include:

- developing an evidence based talent identification model;

- being a champion for and piloting a talent identification tool; and
- establishing a NE Leadership 'Academy' (p. 6).

The South East Coast document⁽¹³⁸⁾ contains many 'tick boxes'. South Central⁽¹³⁸⁾ has an ambitious vision for leadership development and has made significant progress in its role responsibilities towards the twelve leadership commitments. It is stated that within five years:

- leadership development will be 'the norm, not the exception;
- the right of thousands, not the privileged few'; and
- a 'core activity, not a bolt on optional extra' (p.4)

The vision is spelled out by time period: 2008/9 (context); 2009/10 and 2010-2013. Research and evaluation is seen as essential (p. 5). The South West⁽¹³⁹⁾ stresses that leadership development is undertaken on a co-confederacy model. It sets out the 'five frames' model of the NHS Management Board (Inspiring Change in the NHS: Introducing the five frames):

- performance and health;
- the discovery process;
- the influence model;
- change architecture; and
- the benefits hierarchy (p. 1).

NHS SW 'intends to draw upon this approach', but no further details are given. (pp. 3-4). The West Midlands⁽¹⁴⁰⁾ places a particular emphasis on Executive Leadership development: '*Equality and diversity will be a cross-cutting theme underpinning all leadership activity*' (p. 3). The West Midlands is one of the few SHAs that discuss behaviour change. However, apart from the comment that all CEs and their senior teams must own the TM system and cascade it down through the organisation (p. 6), there are no further details of how this is to be achieved (p. 8). The Yorkshire and Humberside⁽¹⁴¹⁾ document stresses that in such a complex world it is impossible to create a grand plan or fully designed system for Leadership Development (LD) and TM where every aspect is planned out, the system is fully engineered, and the outcomes and consequences can be predicted. The 'strategy' includes:

'developing a good enough vision;
generating a few simple rules and minimum specifications; and
building on and promoting existing approaches that have
benefits' (p. 13).

The approach, therefore, is presented as dynamic and reactive (p. 15).

5.4 Diagnosis

The DH guidance⁽¹⁰⁸⁾ states that 'diagnosis' describes the current leadership capacity and capability:

'the demand, the supply, the diversity profile, the gaps between supply and demand, and how these need to change to deliver the regional clinical vision' (p. 17).

By diagnosing the current demand and supply, a gap analysis can be conducted looking at the current, 0-1 year, 1-3 year and 3-5 year forecasts. Talent and leadership assessment processes (appraisals) and development processes (e.g. ACE programmes) need to be aligned. Individuals need to be assessed not only on their current performance, but also against their potential and ambition. It is the ambition in 2009 for the dashboard to be used as input into the assurance dialogues between the SHAs and the DH. When considering the diversity profile, it is useful to seek evidence of the progression of different groups by level, and to look at longitudinal data by group from the staff survey (p. 19).

Details of the SHA Dashboard are set out, all with 'RAG status' which is the ratio of actual to demand, with **Red** being equal to or under 1.0, **Amber** being between 1.01 and 2.99, and **Green** being at or over 3.0⁽¹⁰⁸⁾ (pp. 24-5). The 'Spoilt for choice' diagram sets out demand, supply and gaps for 'ready now' talent (0-1 year) and 'growing' (or ready soon, 1-3 years) talent for CEs and Directors. 'Encouraging everyone to spot talent' gives staff in talent pools for 'Chief Executives 1 in X Executive Directors' and 'Directors 1 in X assistant Directors'; and the number of staff added to regional pool for emerging talent last year. 'Encouraging more clinicians to become leaders' identifies the percentage of ready now talent pool for CE who are clinicians and doctors. 'Reflective of our communities' gives the percentage of the ready now talent pool for CE who are from BME backgrounds, women or those who have a disability. 'Transparent about what is required to progress and supportive of staff to get there' gives managers responding to the NHS Staff Survey saying that they: have had an appraisal and personal development plans (PDP) discussion; have received the training, or development identified in that plan; and have been supported by their manager to access this agreed training, learning or development.

Although being 'spoilt for choice' (SFC) is a key theme of the guidance, nowhere is it clearly defined. In particular, 'desired' is not defined. A RAG status of green assumes that 'actual' must be three or more times 'demand'. Most SHAs stated that being SFC required three qualified applicants for each post. For example⁽¹³³⁾:

'we are required by the DH to amplify our vacancy requirements by a factor of 3 (SFC) to reflect the desire to see 3 suitable candidates per vacancy' (p. 44).

The rationale for this is not made clear, but appears to derive from a speech by David Nicholson (see NLC⁽³²⁾).

Most SHAs multiplied predicted turnover (demand) by three to reach 'desired'. However, this assumes that the two unsuccessful applicants for Interview 1 will never be interviewed subsequently, and that Interview 2 requires three *different* interviewees. Making a different assumption that unsuccessful interviewees in Interview 1 will appear at subsequent interviews gives a rather different figure of $N+2$ rather than $N*3$. For example, the different assumptions for 5 interviews give a 'desired' or 'spoilt for choice' pool of 7 rather than 15. This suggests that in quantitative terms the SFC 'desired' figure significantly overestimates the required talent pool, and so the NHS is more SFC than it appears. The calculations also assume that SHAs are 'sealed' systems and there is no *net* movement between SHAs, or that 'exports' equal 'imports'. However, this is unlikely to be the case as different areas may have different levels of attraction and retention. For example, areas with historic reputations for developing talent are likely to be net exporters, like football clubs with reputations for excellent youth coaching systems. It follows that the figures based on the 'sealed' system assumption are likely to over-estimate the level of SFC in some regions, but may under-estimate it in others.

On the other hand, there are indications that the SFC 'desired' figure may underestimate the required talent pool on qualitative grounds. Most of the SHAs stress that the figures in their first plan are crude, and much work is required to increase their validity. For example, as a first approximation some SHAs equated their talent pools with 'Aspiring' people on courses. In other words, it is assumed that everyone on ACE courses have the potential to be a CE, or that the translation rate is 100%. However, this is unlikely to be the case (see Cohort interviews: Chapter 8).

Similarly, there is some conceptual confusion about the targets for under-represented groups. The DH guidance⁽¹⁰⁸⁾ was unclear about whether the target should reflect the population or the workforce. For example, 'everyone counts' is defined as when the profile of leaders reflects the workforce and communities they serve (p. 10). Similarly, SHAs are asked to consider whether the vision ensures that the leadership workforce profile reflects the wider workforce and local communities (p. 18). However, later they are asked whether targeted development interventions are in place to ensure that talent and leadership pools are reflective of the wider workforce (p. 20). The Government Equalities has laid down national

targets for the composition of public Boards with respect to gender, ethnicity and disability⁽¹⁴²⁾. However, the NHS has set *local* targets as the composition of local communities and workforces vary. However, targets may be very different if they are based on population or workforce, and it is unclear whether the desired reference point is the total workforce or the managerial workforce. For example, the gender target would be about 50% if based on population, but about 70% if based on workforce. The DH guidance⁽¹⁰⁸⁾ stated that there should be higher levels of clinical and medical representation in senior management, but little information about the current situation was given.

Although all SHAs presented some of this information, no SHA appeared to have presented it in full (see Table A.1 - Appendix 2). However, most stressed that their July 2009 plans were a first effort, and that much work was required to improve data in subsequent years. As Table 3 shows, many of the SHAs did not present a clear RAG analysis. While some supplied much data, it was not in a format to enable direct comparison with other SHAs, and some showed data in tables without the precise figures. There is some variation in SFC data for the SHAs that gave comparable data. Some SHAs such as EM⁽¹³³⁾, NW⁽¹³⁶⁾ and YH⁽¹⁴¹⁾ claim to be SFC for most or all of the categories. Indeed, Yorkshire and the Humber (2009: 13) state that low turnover of CE and the relatively high number of aspiring individuals could present the region with a unique problem: *'it may become necessary to manage expectations of this particular talent pool who could be faced with stagnant career prospects'* (p. 13). However, some SHAs gave different assumptions and targets. For example, EE⁽¹³²⁾ assumed two candidates per vacancy, while YH⁽¹⁴¹⁾ specified two to three. Different targets for BME and gender (based on population or workforce) and for clinicians and doctors were given. Finally, as discussed above, most SHAs appear to be SFC on our N+2 figures rather than their N*3 figures. On the other hand, it is likely that the 'supply' data overestimates the available talent so that SHAs may not be really SFC. For example⁽¹³⁵⁾, the supply figure consists of 49 individuals nominated onto programme by CE. This means that the readiness of these individuals has not been objectively determined and this is something we would look to do in the future, with the figure being 'purely a starting point' (p. 15). WM⁽¹⁴⁰⁾ considered that 5 of the 63 individuals (8 %) on the ACE, and 22 of the 88 individuals on AD were 'ready now'. The supply figures in WM tended to be below 'demand' (projected vacancies), let alone 'desired' (vacancy*3), but a more lenient definition of 'readiness' may have seen WM SFC.

Some SHAs gave more detailed and disaggregated analysis. For example, London⁽¹³⁴⁾ provides more detailed analysis for Directors, with some concerns for categories such as Finance, HR, Commissioning and Strategy. South East Coast⁽¹³⁸⁾ (2009: 10) states that the Dashboard is 'encouraging'

and indicates that overall they will be able to meet the demand for senior leaders that they already possess, but there are particular skills gaps in the areas of commissioning and finance but also to a lesser extent public health, operations, MD and communications/public engagement roles (p. 10).

Table 3. SHA Dashboard Status: Red, Amber, Green Analysis (RAG)

SHA	CEs Ready Now	CEs Ready Soon	Directors Ready Now	Directors Ready Now
EE	Green	-	Amber	-
EM	Green	Green	Green	Amber
London	Amber	Amber	Red	Green
NE	-	-	-	-
NW	Green	Green	Green	Green
SC	-	-	-	-
SEC	-	-	-	-
SW	-	-	-	-
WM	-	-	-	-
YH	Green	Green	Green	Green

The spotting figures are presented differently. Some SHAs appear to be spotting talent in that ratios were above 1.0 for CE and Directors (EE⁽¹³²⁾, EM⁽¹³³⁾), but generally ratios were higher for CE than for Directors (NW⁽¹³⁶⁾: 1.19 for CE, but 0.48 for Directors; SEC⁽¹³⁸⁾: 1.9 for CE, but 0.8 for Directors; SW⁽¹³⁹⁾: 1.3 for CE and 0.9 for Directors; WM⁽¹⁴⁰⁾: CE is 0.42 and 0.15 for Directors).

There appear to be no consistent targets for clinical and medical representation. For example, the NW⁽¹³⁶⁾ SHA target is 25% of the CE talent pool with a medical background and 50% of the talent pool for CE with a clinical background. For SEC⁽¹³⁸⁾, of the individuals in the CE and Director talent pools, 14% have a clinical background and 16% have medical background, with the resulting total of 30% exceeding aspirations to have 25% with medical/clinical backgrounds. In the SW⁽¹³⁹⁾, some 27% of CE are clinicians, and the SHA has set the ambitious target of increasing

this to 50% within the next 5 years. Some 63% of participants on the Top Leaders programme hold a clinical qualification of which 38% are doctors.

Most SHAs recognise that BME staff in existing senior management and talent pipelines are not representative of the workforce or community. For example⁽¹⁴¹⁾, the data on senior management *'does tell a familiar story that is of little surprise. The senior leadership population is predominantly white, male, and in the higher age brackets'* (p. 10). This is a stark reminder that considerable work needs to be undertaken to enable the progression of individuals from BME backgrounds to senior positions: less than 4% of combined Band 8 workforce originates from a BME background (p. 11).

The situation appears to be more optimistic in terms of gender, but is blurred by the unclear target, depending on whether it is set in terms of population or workforce. Most SHAs did not present data on disabled people, but the few that did showed that they were relatively disabled people in senior management or the talent pipeline.

Finally, not all SHAs presented Staff Survey data, and the WM⁽¹⁴⁰⁾ were one of the few to set data against national averages: appraisal (61% versus 59% nationally), identified training (30% versus 29%) and support (34% versus 35%).

5.5 Plans to close the gaps/ Pathways and investment

The DH guidance⁽¹⁰⁸⁾ defines *'plans'* as the regional collaborative actions required to deliver improvement and to close the identified gaps between demand and supply and the required leadership for quality, and *'pathways and investment'* as the investment in leadership development to be made and how this aligns to models of care, patient pathways and region priorities (p. 17). In more detail, plans are concerned with how gaps will be closed, but:

'to close the gaps between demand and supply successfully, talent management 'pathways' aligned to models of care and patient pathways will need to be strengthened. We anticipate that this section will describe what the pathways are and where investments will be made at local, regional and national level. (pp. 20-1).

However, in this sense, *'pathways'* appear to be an important part of *'plans'*, and investment appears to be closely linked with *'plans'*. The difference between plans and pathways was not fully clear in many SHA documents. For example, London⁽¹³⁴⁾ both sections are discussed together. The East of England⁽¹³²⁾ gives details in plans (7 pages) and pathways and

investment contains a broad summary of one page. The South West⁽¹³⁹⁾ examines broad activity in the former section, and groups clinical and BME in the latter. Both sections are discussed together below.

As Table A.2 (Appendix 2) shows, most SHAs had much actual and planned activity, and varying budgets. In addition to Aspiring CE and Aspiring Director programmes, most were involved in activity to build clinical leadership and diverse leadership. Some had set up courses aimed at gaps such as Aspiring Nurse Directors, Aspiring Directors of Public Health and Aspiring Directors of HR. Most were involved in various types of coaching, mentoring, networking and Alumni development. Some had set up Masterclasses and Summits. A few stressed commissioned research projects.

5.6 Links to System-Wide Initiatives

'Links' in the DH guidance⁽¹⁰⁸⁾, describes regional and local talent and leadership activities on system-wide priorities such as quality and world class commissioning. It makes explicit how the talent and leadership plans support PCT world class commissioning organisational development plans (p. 17). It is noticeable how certain parts of the 'system' are stressed in the national and SHA documents. Attention is focused on PCTs, and there is relatively little discussion on provider Trusts, let alone Foundation Trusts (FT) over which SHAs have little authority. The unstated definition of the 'system' glosses over a key 'fault line' in NHS talent management (see interviews). Some were very clear that talent was the property of the 'system', while others were equally clear that talent was the property of individual organisations. The DH guidance⁽¹⁰⁸⁾ appears to subscribe to the former view:

'behaviour may need to be challenged where there is evidence that organisations are hoarding talent rather than being stewards of it' (p. 27)

but it is unclear how behaviour can be changed when there are few effective levers over some organisations.

This section tended to be brief. For example, it amounted to one page in the London⁽¹³⁴⁾, and North West⁽¹³⁶⁾ documents, and 14 lines in the NE⁽¹³⁵⁾ document (pp. 30-1). SEC⁽¹³⁸⁾ contains a page on 'governance for delivery' where it is stated that NHS SEC 'works with organisations across the region to agree and deliver talent management and leadership', and a 'tick box' of 7 lines of system-wide development (pp. 14-15). Most stressed the engagement of by giving information on the proportion of organisations that submitted returns.

5.7 Barriers and Risks

'Barriers and risks' in the DH guidance⁽¹⁰⁸⁾, describes the challenges that can be addressed locally and regionally and what needs to be addressed at a national level (p. 17). This section should describe the barriers and risks that need to be addressed at national, regional and local levels. Mitigating actions for those risks with the highest probability and impact will be outlined. (p. 23)

As Table A.3 (Appendix 2) shows, some SHA documents ignored barriers. Some did not explicitly differentiate between national, regional and local levels. Some presented a risk matrix, with the dimensions of probability and impact. They were asked by the DH to focus on high probability/ high impact- but these risks were often described in limited detail. North East⁽¹³⁵⁾ does not have a section on barriers and risks. East of England⁽¹³²⁾ gives a risk matrix in an Appendix, which is differentiated by probability and impact, but not by level (p. 31). East Midlands⁽¹³³⁾ does not discuss barriers but sets out risks with management action by level, but there is no differentiation by probability and impact (p. 35). For NHS London⁽¹³⁴⁾, the barriers and risks to our T&LP arise directly from the scale and complexity of our operations. It sets out principal risks and a risk matrix differentiated by probability and impact, but not explicitly by level (p. 31). North West⁽¹³⁶⁾ does not have a section of barriers and risks per se, but recognises challenges- attraction, recruitment and retention; widening participation; the economic climate; external recruitment; senior clinical engagement; skills shortages; board development; Non-Executive Director development (pp. 15-8). It also sees a priority of systems barriers and risks assessment: to carry out a review, and plan contingencies and minimisation of risk accordingly (p. 41). South Central⁽¹³⁷⁾ presents a table of risks and barriers and mitigating actions, differentiated by level, but not by probability and impact. Moreover, while it recognises national and local risks and barriers, there is no discussion of the regional level (pp. 36-7). South East Coast⁽¹³⁸⁾ presents a table of risks and mitigating actions, differentiated by level, but not by probability and impact (p. 16-7). The South West⁽¹³⁹⁾ sets out 'system barriers and risks', but appears to focus only on risks, which are differentiated by level, but not by probability and impact, although mitigating actions are given (pp. 35-8). The West Midlands⁽¹⁴⁰⁾ examines barriers only with respect to inclusion, and risks (p. 12). Risks are set out by level, with probability and impact, and actions to mitigate them (pp. 28-9). However, there is no focus and detail on the two high probability and high impact risks, which are both at regional level. Yorkshire and the Humber⁽¹⁴¹⁾ did not have a section on barriers and risks, but recognises 'what needs to change' (p. 17-8), and lists 'pre-requisites for system wide T&LP (p. 27).

5.8 SHA Assurance

We have linked talent management with one question from 'Finance' (Arena 3) and eight from 'Workforce' (Arena 5), with its governing question: 'how well is the SHA prepared to deliver tomorrow's workforce to meet the challenges of delivering the regional clinical vision, Quality, Innovation, Productivity and Prevention (QIPP) and the NHS Constitution?' The relevant Assurance questions are:

5.8.1.1 Arena 3: Finance

(3.4) Have implications of savings been factored into workforce and capacity planning?

5.8.1.2 Arena 5: Workforce

(5.1) Can the SHA demonstrate how they are bringing the NHS Constitution alive? (focus on staff and patients)

(5.2) How is the SHA using the NHS Constitution to personalise services?

(5.3) How is the SHA assured that the staff rights, responsibilities and pledges are fully embedded so engaged staff are delivering commissioned services?

(5.4) Can the SHA demonstrate how the shape of the workforce needs to change to enable the regional vision (including QIPP and other national priorities)?

(5.5) Can the SHA demonstrate:

- Regional collaboration on the planning and development of the required workforce?
- World class education commissioning?

(5.6) Can the SHA demonstrate how it is leading the development of Talent and Leadership planning?

(5.7) Can the SHA demonstrate that Talent and Leadership is being developed to meet medium and longer term needs?

(5.8) Can the SHA demonstrate how they are going beyond being legally compliant and in addition have clear action plans to promote both workforce development and service provision for itself and the region moving towards 'Everyone Counts'?

Table 5 presents data from the available SHA Assurance Reports. Scores for the workforce arena was broadly low (on a 1-4 rating), and generally workforce tended to be among the lowest scores of the 10 arenas. For illustrative purposes (assuming equal weights) a total and average score have been calculated. There is relatively little variation between the SHAs,

with East of England⁽¹⁴³⁾ the highest and South East Coast⁽¹⁴⁴⁾ the lowest. In terms of the Assurance questions, the highest scores were associated with 5.4-5.6, and the lowest scores with 3.4 and 5.8.

However, according to the Assurance panels, most SHAs did fairly well on the workforce arena. For example, on balance, the East of England SHA⁽¹⁴³⁾ is doing well on the NHS Constitution and the Talent and Leadership agenda, however, they are less effective on workforce planning and appear to react to the situation rather than having a clear vision of the future workforce and driving this forward. It is felt that there are areas for improvement on diversity issues with no clear defined strategy to deliver a major step change in this area. The North West SHA⁽¹⁴⁵⁾ are:

'... at the forefront of many improvements being made nationally, are extremely active in national networks, and have taken a bold approach in tackling inclusiveness and investing in skills and leadership'.

Table 4. SHA Assurance

	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH	Total
3.4	2		1		1	2		3			9
5.1	2		2.5		2	2		2			10.5
5.2	2		2.5		2	2		2			10.5
5.3	2.5		2		2	2		2			10.5
5.4	2.5		2.5		2.5	2		2			11.5
5.5	2.5		3		2.5	2		2.5			12.5
5.6	3		2		3	2		2			12
5.7	2		2		2	1.5		2			9.5
5.8	1.5		1.5		2.5	2		2			8.5
Total	20		19		18.5	17.5		19.5			

Broadly similar themes arose from responses from staff members within the SHAs. The 'headline' for four of the five SHAs is that 'capability and talent development mechanisms could be improved'.

There are general criticisms of:

- appraisal and performance development reviews;
- the lack of a link between performance and consequences;
- scope to strengthen the use of coaching, internal training, job assignments and job rotations to drive talent development at all levels;
- organisations not collaborating effectively with one another nor consistently sharing ideas or best practice; and
- that talent management and development could be improved.

For London⁽¹⁴⁶⁾, the main point is a lack of strategic alignment and collaboration. There needs to be more clarity on how different parts of the system fit together to deliver the overarching regional strategy. Stakeholders are uncertain how individual organisational strategies complement one another in delivering system-wide improvement.

5.9 Conclusions

It can be seen that there is no shortage of vision, investment and activity for TM. However, it is too early to determine whether this will translate into positive results. Although both the DH and SHA documents stress that it is 'early days', there are a number of issues that may undermine the TM strategy. First, there is a lack of conceptual and empirical clarity. The definitions of 'SFC' and a representative senior leadership are far from clear. Second, few documents give much attention to the deep cultural and behavioural issues that may prevent a successful strategy. Third, there are many different processes, and there is little evidence that particular courses or tool kits represent 'best buys'. Finally, it is not clear whether there are sufficient levers for system change when parts of the 'system' appear less engaged than others, reflecting a deep divide between whether talent is the property of the system or organisations.

6 Stakeholder and SHA Interviews

6.1 Introduction

This chapter presents interviews with SHA and central stakeholders (e.g. national organisations) in order to 'get behind' the information arising from the central and SHA documents (Chapter 5) and to explore different approaches between the SHAs. The SHA interviewees (1-11) have a number of job titles such as SHA, CE, Leadership Manager, Head of Leadership, Associate Director, Chair of TM Steering Group, and those associated with Academies. Our national 'stakeholder' interviewees (A-K) consisted of a member of the NLC, representatives from national organisations, and those with particular knowledge of component parts of the TM system. In this sense, these interviews represented more of a 'population' than a sample.

6.2 Method

We followed Silverman's⁽¹⁴⁷⁾ suggestions to enhance the overall reliability of qualitative research: thorough pre-testing of interview schedules by comparing how at least two researchers analyze the same data; conducting the interviews as far as possible under standard requirements; and presenting 'low-inference descriptors'. According to Seale⁽¹⁴⁸⁾:

'... recording observations in terms that are as concrete as possible, including verbatim accounts of what people say, for example, rather than researchers' reconstructions of the general sense of what a person said, which would allow researchers' personal perspectives to influence the reporting'. (p. 148)

Similarly, Silverman⁽¹⁴⁷⁾:

'Interview studies must satisfy the criterion of using low-inference descriptors by: tape-recording all face-to-face interviews; carefully transcribing these tapes; and presenting long extracts of data in the research report.' (p. 287)

Moreover, we aimed to make the research process transparent through describing the research strategy and data analysis methods in a sufficiently detailed manner in the research report, and by paying attention to theoretical transparency through making explicit the theoretical stance from which the interpretation takes place (but see below).

We also considered internal and external validity. Internal validity refers to the extent to which researchers demonstrate that they present the reality from the interviews, and is often seen as the most important aspect of validity in qualitative research. External validity refers to the generalisability

of the research, the extent to which the results are applicable to other similar situations. We followed the following approaches to enhance internal validity:⁽¹⁴⁹⁾

- triangulation (the combination of multiple theories, methods, observers, and empirical materials to produce a more accurate, comprehensive and objective representation of the object of study);
- peer debriefing (through the Advisory Group and conference presentations);
- probing (open questions in interviews); and
- cross checks (drawing on as many different sources of data as possible to check out interviewees' statements)

Like most qualitative studies, we did not attempt to produce 'statistical generalisation'.⁽¹⁵⁰⁾ Bryman⁽¹⁵¹⁾ points out that qualitative research follows a theoretical, rather than a statistical, logic; thus: *'the issue should be couched in terms of the generalisability of cases to theoretical propositions rather than to populations or universes.'* (p. 90) In order to achieve this we adopted theoretical or purposive sampling, which is defined by Mason⁽¹⁵²⁾ as:

'... a set of procedures where the researcher manipulates their analysis, theory, and sampling activities interactively during the research process, to a much greater extent than in statistical sampling'. (p. 100)

The expertise, knowledge and contacts of members of the project team were used to identify the respondents for this stage of the research. This provided access to a range of national 'experts' from organisations who were working in the TM field in health, and initial contact points for access to some of the SHAs in England. The remainder of the SHAs were invited to participate through relevant contact details available on the organisations website.

The invitation to participate was by telephone or email, which provided details about this stage of the project and what would be expected of respondents, and stressed the confidentiality of the responses given. All respondents were supplied with a copy of the project summary and a participant information sheet (Appendix 3). The majority of the interviews (19) were undertaken by telephone, with the other three in person. With the permission of respondents all interviews were digitally recorded and subsequently transcribed. Completion of project Consent Forms was requested at the time of interview. All of the interviews, except two, took place between December 2009 and the end of January 2010. The other two both took place in June 2010.

The interview schedule (Appendix 3) is derived from the main themes that emerged from the literature review and the focus group sessions. The main areas covered included:

- interest and involvement in TM and leadership development;
- understanding of the development of the current TM initiative;
- differences between TM and previous methods;
- how to best identify the talented manager;
- how to best develop the talented manager;
- issues around retention of talent;
- linking individual development with organisational success;
- the challenges in setting up the TM initiative;
- TM in a 'cold economic climate'.

In-depth, open-ended interviews lasting between 45 minutes and 1.5 hours allowed participants to have the space to introduce and reflect on issues that they perceive as relevant.⁽¹⁵³⁾ We chose to manually (rather than electronically through computer packages) analyse the data because it was felt that with a reasonably manageable number of interviews this was the best way to 'get close' to the data. Verbatim quotations were chosen to achieve 'low-inference descriptors' (above).

6.2.1.1 Limitations of Stakeholder and SHA Interview Method

There was no obvious problem with representativeness and bias as the interviews were conducted with a defined population. Issues of reliability and validity were addressed through pre-testing the interview schedule, recording interviews, a transparent research approach and two researchers independently analysing the findings. As noted for the Focus Groups, comparing the data to 'theoretical propositions' was problematic as the theoretical foundations of TM generated from the literature review (Chapter 2) were far from clear. Loose 'theoretical propositions' were generated from the rather vague 'best practice' from the literature and from the objectives and pathways of the SHA TLP (Chapter 5).

All audio transcripts were reviewed independently by two members of the project team, to identify the main themes that are presented in the analysis that follows.

6.3 From 'managing talent' (mt) to Talent Management (TM)

This section examines the journey from 'mt' to TM. The respondents reported that, apart from the MTS (in various guises) which had been running 'since the year dot' (6), arrangements tended to be rather informal and ad hoc. There was 'no system' and the picture was 'very mixed', ranging from 'excellent' to 'pretty woeful'. Networks were important, and patronage was potentially a major problem:

"Whoever was top dog in a region at the time had the pick of his favourite people and picked them when he needed them." (A)

"It was a question of being 'on the radar'." (2)

Some pointed to the initiatives of Nigel Crisp as NHS CE who pushed the new TM agenda, set up a 'little black book' to identify the 'top people' (see Chapter 3):

"Nigel Crisp set up more like a M&S programme- 'let's identify the best leaders and shove them all around the country'." (G)

Some informants were not particularly clear how the current initiatives came into being. However, others pointed to the influence of the setting up of SHAs, David Nicholson, the National Leadership Council, and the Darzi Report. However:

"Darzi ended up being very, very thin on leadership. There was not a huge agreement on what to do- loads of different hares running and not an enormous amount of consensus about what to do. What was in the report was quite bland." (7)

Some claimed that there were addressing issues and running courses before the DH national guidance of 2009. For example:

"We were addressing TM before it became a national issue, and were leading the way at the time." (5)

However, the basis of the current system was seen to be the DH Guidance for SHA talent and leadership plans, 'Inspiring Leaders'⁽¹⁰⁸⁾. This was regarded as more 'joined up' and 'systematic':

"The first time that we have systematically objectively provided an opportunity to review talent at many levels within the system. By making it more systematic, what we're doing is levelling the playing field." (10)

"... new imperative around systematising it more on a national level." (D)

6.4 Talent Management, Leadership and Leadership Development

The DH guidance⁽¹⁰⁸⁾ examines both leadership and TM, but gives no clear definition of TM. Some of the interviewees admitted that they were not fully clear on these distinctions, but advanced a few suggestions:

"I'm not sure I understand the distinction between the two. TM is probably wider than leadership?" (E)

"The important thing for me about TM is not just managing the high powered talent, it's the every day talent. It is every bit as important to manage the average and good talent as opposed to simply the outstanding talent." (H)

"For all the talent, not just 'let's pick up the high flyers'; we did not want to lose the average person anymore than we wanted to lose the high flyers; wider talent pool- need the not quite so bright and not quite so best as well as the brightest and the best." (I)

Although it was generally agreed that the post-2009 system was a massive improvement, there were concerns over two main issues. The first is variability, with NW, EE and London variously seen as being in the vanguard:

"I keep mentioning NW and EE because they're the furthest ahead of the others. NW 'blazed a trail'; we were able to point to them and say these are the benefits that they have seen from it." (10)

"NW and London as leaders." (E)

The second is sustainability:

"There have been a few false starts." (J)

"Littered with a track record of failure around this." (I)

"A fairly constant recycling of passing some of the same people and some of the same policies with a fresh spin: eg Leadership Centre-current not a different animal, but another version of the same animal; another incarnation of something we have had before." (F)

Finally, it was stressed that it was 'early days' or the 'beginning of the journey' for TM:

"We've gone all through the process and filled in all the forms and written some glossy documents. But that's step 1 of 100; tentative first steps." (A)

6.5 TM in the NHS

There was some discussion whether it was possible to have the sort of TM that leading private sector companies have, as private companies are single organisations that are more able to 'direct' talent:

"The private sector have names of you know 'when Mary's brought her 3 children up we'll ship her to Abu Dhabi or something.'" (A)

"Partner said we have TM service at work; but not in it because not prepped to move anywhere in the world, and that is a prerequisite of being on a TM programme." (I)

"In the private sector some chief operating officers spend about 50% of their time developing their successors; we are never going to get there." (5)

"We are not talking about a single organisation, like M&S or the army." (B)

"More federal or independent bodies; not like one company such as Microsoft with TM scheme. More unified approach to TM as they do in the private sector is more difficult." (2)

A related point is whether there was a 'system' in the NHS, or a collection of organisations, which had implications for whether the 'system' was competitive or collaborative. It is unclear:

"... whether the NHS is a system, an organisation or a set of different organisations." (F)

"Fundamental difference of view between some people who see the NHS as a single organisation and those people who see it as a sector made up of individual and increasingly independent players." (E)

There were some strong arguments for a collaborative system:

"You can identify an added value in advertising the NHS as a national brand rather than those 300 plus individual employing organisations." (K)

"My strategic purpose is to build talent for [SHA] but of course I have a national responsibility as well." (5)

"CE sometimes jump up and down and say how dare you 'poach' this person, but I regard them as the property of the system and not the property of your organisation." (9)

"To some extent TM requires an element of altruism, working for the greater good of the system, not simply for your own good." (C)

However, there were equally strong arguments for a more competitive system:

"In what sense has the DH or NLC to intervene in terms of how a particular FT approaches the development of its staff? They are its staff, they are not the NHS' staff, and there is a fundamental difference of view here, so Claire Chapman sees herself, in a sense, as the head of the HR function for all 1.3m people in the NHS, and that's fundamentally different from how Monitor and the FT see the world. I have a strong personal preference for the sector rather than the organisation model." (E)

"What are the SHAs doing playing in this territory, what on earth has it got anything to do with them for? Hoarding your best staff is absolutely what you should do as leader of an NHS organisation." (E)

"[SHA] it's none of their business frankly." (F)

Some pointed to the problems of NHS 'culture' of patronage and the 'old boys network':

"Trying to rid of the old boy's network and tapping him on the shoulder." (5)

"We know who the SHA team like and who they don't. They often like the people who manage their reputation well but not their organisation. We are talking about patronage. If your face fits you get everything and if your face doesn't you get nothing." (A)

"Used to move people around on a chess board, but real dangers if only males on board." (G)

"We need to direct talent – I have had some really good Directors who I would have liked to keep but they really needed to move on, and so I contacted another CE to say 'you really need to look at this person' – it sounds awful and it's probably against every equal opportunity thing. I agree we probably are talking about patronage. But we need a broader patronage- leadership community not just CE or SHA." (G)

Another cultural problem was having the 'honest conversations' or 'open conversations' necessary to deal with poor performance:

"Really honest feedback requires a significant cultural shift." (7)

"One of the things we do appallingly in the NHS is actually deal with people who don't perform. You'll find them reincarnated somewhere else again and again and again and it brings the credibility of the system into disrepute. It puts off some of our good managers and it takes up key roles with people who can't really perform in them. It wouldn't happen in the private sector ... and it shouldn't happen in the NHS. They would be out." (A)

6.6 Context

Context was regarded as important in two main ways. The first relates to flexibility to adapt the central guidance. There were only a few 'must do's' in the guidance, but it was subject to SHA Assurance:

"The DH never actually specified 'you will do this programme'. It was more about a process: 'you will need to start spotting your

talent, put them into the right talent pools and then determining appropriate development initiatives to support them'." (3)

"SHA Assurance is rigorous and high level. The Assurance document is ½ inch thick and our response was in the form of something that looked like a telephone directory." (3)

The second relates to local circumstances. There are:

"Different approaches in different SHAs." (1)

"Difference governance models in SHA- eg Academy. We are looking at whether there's a [X SHA] way." (3)

"We try and adapt it [NLC] to fit for local purpose." (4)

"We're always finessing between what is nationally required and what is locally desired." (1)

One factor behind the variation is geography:

"Cross boundary flows, dependent on geography- different in different parts of SHA." (3)

"Wide differences in the nature of our geography: what works in one place wouldn't work in another." (3)

Another factor was the number of FT in the SHA:

"We are 'very FT rich'. We have no authority over FT; have to work by agreement and partnership because we can't require). Although DH can require SHA to report, SHA cannot require FT to report." (1)

Mobility and turnover varied between and within the SHAs. In particular, SHAs or parts of SHAs close to London can 'haemorrhage talent'. For some regions:

"Low turnover for CE. No problem with retention. Lot of ACE who are getting 'very frustrated', so keeping numbers low [on ACE programmes] because we just don't have the demand." (1)

"Stable and static workforce; do not want to move. Low turnover equals low opportunity; some look outside." (4)

"... a lot of organisations where turnover is quite low; it obviously depends what other work is around. There are parts of the country like the SW where they are very dependent on the NHS for employment." (H)

Although there were some national 'givens' (such as running an Aspiring CE programme), SHAs saw a range of different problems and issues, and this resulted in a variety of programme lengths, content, and delivery agents. The combination of some flexibility and differing local circumstances results in variation between and within SHAs:

"All SHA have moved on at different rates and have had different issues and problems." (8)

"Different parts of the country will have different approaches, different organisations will use different approaches." (11)

"Variation around the regions- different culture; different sets of issues." (C)

"Different to rest of country- Director more gap than CE- never has been problem in attracting good CE as near London and good place to live." (11)

"In many areas we are SFC, so we decided not to run a third cohort for AD." (6)

"Showed early gaps in some functional areas and more for Directors than CE." (11)

"ACE are lesser priority." (11)

"Some small SHA too small for ACE; only a few truly aspirant CE at any one time." (6)

There were some different views about the 'Academy model'. It was generally felt that the North West Academy led the way, and that some other SHAs were using that as a model, but others discounted it

"NW Academy- held up as flagship by everybody; really rated by DN." (4)

"The Academy model is useful because of ownership: if people have to put their hands in their pockets, they are more willing to participate and help shape the agenda." (4)

"For FT, moving to Academy the best thing, as it's not seen as the SHA doing it." (4)

"We looked at Academy model, but can see benefits of 'an academy which is owned by the system', keeping it within SHA." (5)

"We like the Academy approach because membership gives some responsibility and ownership." (7)

"Discounted Academy due to business climate; not right time; VFM issues." (8)

6.7 System/ component parts

Respondents gave some views on the longer standing main national component parts of the system: MTS, Breaking Through and Gateway. The longest standing programme is MTS:

"MTS has much longer history, and is about capacity and capability much earlier in the Talent pipeline." (K)

"Main aims of MTS have remained the same all the way through; a quote from 1956, from the very beginning, talks about getting the best people to fill senior posts." (B)

"One of the big issues has been who owns and organises scheme-centralisation/ decentralisation issue. Initially centrally driven; 70s, 80s and early 90s- regionally driven, and now back to being centrally driven. But does see NHS as single employer entity, and increasingly with FT and IS, issue will emerge gain. It keeps being reviewed and the pendulum swings one way and then the other." (B)

"MTS is very well regarded, tends to win prizes, around 230 people each year and costs around £25m pa, but what's the right number?" (J)

Several informants pointed to the 'track record' of MTS in producing leaders, particularly David Nicholson:

"... so what greater example would you want of a system delivering its leader?" (D)

"... he is the leadership that he wants to see. He has come up through the system and really enacts the leadership that he asks us to do." (G)

"Four of five last CE from MTS; but do not know what percentage of directors it produces." (J)

A major concern about MTS was the 'gap' between it and later career schemes:

"MTS etc work quite well but they only go up to a certain point; limited in scope so it's never going to do the full job. 'Big gap' in the middle- between MTS and AD, ACE." (A)

"Even for the fast track, it takes 10-15-20 years to reach top. So there is a massive gap." (B)

The Gateway scheme was regarded as a success, with broadly positive evaluation from participants, but with dangers:

"If you bring ... people in from externally, you'll annoy a whole host of people you have been developing internally." (D)

Finally, Breaking Through also received broad support, and could serve as a wider model:

"... consistently highly rated in terms of selection, programme content and support, but less positive feedback from some of the regional tier of leadership development and that is partly about branding because within the BT brand there are actually at least 3 programmes running." (K)

"What we are hearing from the service is that the three programmes [BT, G, MTS] are about in the right space, if you broaden BT to inclusion. But consensus that there should be an initial entry, something that supports people who are recruited in later career and something around inclusion." (K)

"We are moving to look more at inclusion and what programmes or support or initiatives are needed and would be helpful for people who face barriers to progression to senior levels, whatever those may be. So the groups you [interviewer] mentioned [gender, disability, social class] absolutely right, and equally some clinicians find barriers. Useful to learn from BT to look at all disadvantaged and under represented groups." (K)

A large number of other courses were discussed. While a number of these had been individually evaluated, there was little sense of comparison, attempting to establish whether some were best suited for different purposes, or which were 'best buys':

"There are many good LD courses, but this is essentially a market that is led and dominated by the producers, not by the commissioners. Very little intelligent commissioning, asking what do we need in terms of LD? We are offering generic LD for its own sake, rather than for a purpose." (E)

"LD a remarkably crowded and probably an over crowded field." (F)

6.8 Problems/Issues

Respondents identified a number of issues and problems associated with the TM system. The main issue was the engagement of FTs. Some did not want to 'play ball'. Others were all or largely 'on board', but annoying things such as IT systems' sometimes get in the way:

"The current initiative can drive TM to PCT but not FT. Some FT will be happy to play in that territory, others see no need." (C)

"There's an element of some FT's probably genuinely feel as if they don't need to do it. Some are very well known for high quality TM. If TM is sent down from SHA there is always the potential for reaction against that. Monitor will always run a line which is by all means collaborate but don't do anything that affects your own bottom line." (C)

Another major issue was the identification of talent:

"Identifying talented managers is the 'million dollar question'.. Initially, ACE participants were self identified, but checked by a panel of CE, and they did not have a common understanding of what talent was. Newly appointed CE were looking for skills, while experienced CE were much more looking at potential." (1)

"Talent development within our organisation is probably quite primitive. We have not got very good definitions of talent or criteria for identifying it, or very clear processes for developing it." (1)

"We do not have a common set of understandings about what great leadership looks like. We generally do not use LQF. I think that only one SHA used it as basis for selection criteria for ACE." (3)

"Identification of talent is subjective rather than objective at the moment." (4)

"... we mustn't equate attendance on courses with development." (3)

"Simply do not think we have the rigour. It still relies quite a bit more than it should on individual spotting." (11)

"Very resistant to the idea of using a tool to objectively assess performance because it gives a veneer of objectivity that isn't always there." (7)

"Need more rigorous and transparent process." (7)

"Judgements a little bit subjective and parochial and runs the risk of missing some good people." (A)

"Need to refine talent pool. We have so many AD, but what are they aspiring to be and when are they aspiring?" (2)

"AD more problematic than ACE. CE are more 'standard' but to become a director could mean a myriad of things." (8)

"Dashboard looks precise and scientific, but it is only as good as the information put into it; varies by CE." (6)

"They didn't do it all the same way. It was just guidance, it wasn't meant to be prescriptive, but sometimes it was, kind of, irritating, because you would find that a certain SHA that you could not extract the data in the way that you could say, comparing apples with apples here. I think some of that was probably deliberate, people didn't like being compared, but some of it was we are going to do it our way." (J)

One problem is the lack of a common system or database:

"One thing we miss nationally, and this is a big issue and it's causing a lot of discussion, is that there is no preferred TLM database." (3)

"Need good data that is transferable across the NHS. Do not have a single TM platform or software system that we are all using so that we can compare like with like." (5)

"We need a minimum dataset that it transferable so that my talent means the same to you in your region. Starting to be looked at but we are all very cautious as the NHS is not renowned for the success of its IT programmes." (8)

There was often a lack of consistency between and within organisations, so that different people had different views of 'talent'. In some cases, individuals' views of their talent were seen as optimistic, but in other cases talented people did not put themselves forward or were not spotted:

"Some person wants to be a Director and you kind of think 'well, dream on really' [laughter] Or you see people who seem to have no aspirations and you think 'well why not, they're brilliant'." (A)

"I advertise 8Ds, most senior operational managers and God I could weep at what we get." (A)

"Some PCT Directors feel that they don't feel they're really able to do their jobs. They think they were promoted too quickly, they don't think they've had experience. But these people are now putting down they expect to be a CE next and I think we've got a massive gap in credibility. Function of massive expansion of PCGs and PCTs; some people went from a fourth tier to a top tier in 6 months. I defy

you find any finance person in an acute sector who won't tell you about the gulf that exists between finance in acute sectors and finance in PCTs, it's huge. Generally speaking my son with A level maths could run rings round some of them." (A)

"Some regions were saying that as more than 3 appointable candidates per interview we are SFC and therefore 'green' of measure. But David Nicholson said you are not green, you are not scrutinising your talent pool tightly enough; my experience of sitting on interview panels is that is not the reality. Although people are saying they are SFC, it just doesn't feel as if the rigour is there yet." (J)

The identification of individuals identified as 'talented' might lead to unrealistic expectations of promotion on their part, and demoralise individuals who were not identified as 'talented', with lack of support similar to the '11+ failures' of the selective school system:

"Once you unleash this it has to be effectively managed- eg if 5 people pop up who want to be a Director in 2 years and they probably won't, well what then do you do?" (A)

"ACE and AD has raised expectations, but when we were sitting looking at them you know they were not going to be ACE or AD. We put people on programme- get tick, tick, tick. There was a perception that if we put someone on AD course they would come back as a fully rounded potential Director." (G)

"In recent 3 or 4 CE appointments, none of the people on the programme were short listed. So there's a difference between what an organisation has been saying that this person is ready for a CE job and what's been deemed to be actually somebody for CE." (7)

There were some concerns about TM at the national level, particularly that schemes are not always 'joined up' and over the 'Top Leaders Programme':

"Wish national programmes were more aligned; how do NLC workstreams fit- eg TL with EL?" (4)

"National TM process on top of regional one." (7)

"Not clear who is responsible for what." (9)

"Frustrations- the whole messy bureaucracy at the top end of the NHS. It is very, very unclear who does what and who is responsible for what in this area." (E)

"I think there is a gap in there being an overarching architecture or very high level framework within which activity is delivered." (K)

"Concept of TL causes a lot of anxiety. 'Real dangers' of it becoming around patronage." (F)

"Top leaders- we are still a bit sensitive about some of the figures [250 became 1000] as you could say that the top 1000, or indeed any number is also incredibly elitist. So it's a bit of a tricky one." (J)

"Problem of keeping changing the system- of 800 current on national list, at least 25% will have been on one or other national list in the last 3 or 4 years, that kind of never really went anywhere." (7)

There were also concerns at the SHA level, particularly on variable standards and transferability:

"Our programme acts as a 'kitemark' but probably mean a lot more in 'home' SHA; for most CE passed the Ronseal test; probably interview, but not guaranteed." (I)

"Spreadsheet showed that half of people on AD had been promoted; they may have done so anyway, but at the very least it shows we picked the right people." (6)

"Some of the very basic building blocks for managing talent are not universally there; you can't possibly be spotting talent if you don't have 100% and high quality appraisal processes in place; you are 'missing a trick'." (5)

There was broad consensus that NHS leadership was not representative of workforces or communities:

"AD1 was by nomination by CE. There was some criticism about perpetuating talk of the current in terms of diversity and I think that was probably true. Recreating in your own image is important issue that we have not got our heads round yet." (11)

"We are acutely aware that we have got very low percentages of people, for example, from BME, but we have had some senior people from BME background saying, the last thing I want you to do is to over-promote and tokenism, because that will actually undermine the case." (J)

6.9 Future of TM

At the time of our interviews, savings in management costs had been identified, but not the Coalition government's policy of the abolition of PCTs and SHAs. For some, the future of TM was unclear:

"If I were a betting person, I am not sure what I would say yet." (11)

"It may highlight differences between organisations- some may be more willing to continue to invest than others." (4)

Some saw a positive future for TM:

"TM is an investment, because why wouldn't you invest in people? It is just a piece of good practice; essential." (10)

"The climate has never been better. David Nicholson is nailing his colours to the mast." (9)

"... good TM is about assisting those individuals through a very difficult transition." (C)

"People will need TM more in the current economic climate." (H)

"TM useful to support people during management cuts." (I)

"[Current economic climate] I'm probably a bit of a radical in this regard. I think the NHS gets sloppy when it gets lots of money. And

I think a dose of austerity focuses the mind ... reducing management costs means I've got to know, support, retain the best people I've got and really develop them, and I've got to get rid of those who aren't up to scratch." (C)

Others foresaw a 'cold climate'.

"Everyone will go and slash every training and leadership programme that is around because that is the easiest thing to do." (G)

"... an opportunity to skim money off investment because easier to do than take money out of frontline services. Easy to cut into training and development budgets." (D)

"Economic downturn will 'profoundly' affect the NHS- significant cut in development and training; it always happens in any industry. You can cut in the short term, it's painless, but in the long term it is very damaging." (E)

"It may be easier to deliver in theory than in practice; in difficult economic times, a really coherent TM becomes absolutely, utterly crucial. But easier to cut than to close a ward." (F)

"With cuts in management costs, there is no point in 'throwing more people into the pool'; It may be more a question of quality rather than quantity; a move from capacity towards capability." (2)

"It could be a nightmare. If we believe- and I do- that leadership genuinely does make a difference, then we really, really do need good leadership in the next couple of years, but there may not be continuing political support. I think the jury is out. It would not surprise me at all if come May 8th everybody's told to pack up and go home. But in 12 months time someone will say we have a really big problem filling these big jobs. What we are missing in the NHS is a systematic approach to talent and leadership and they'll start at all over again." (7)

6.10 Conclusion

Some reflections on TM sum up broad views very well. It was felt that it was 'early days' on the journey to TM, and that it was too early to evaluate its impact:

"Jury still out on whether it is working- early days." (C)

"Heading in right direction, but devil is in the detail." (C)

"I'm hoping DH doesn't send out any more TM guidance. Existing went through 38 different drafts." (C)

"You are not going to develop a TM system that has results within a few years [no quick wins] Take a generation so sustaining it is often the biggest single problem." (7)

"Hope it is here to say this time, not another false start; need sustainability. Issue of what happens if SHAs get abolished [but did not expect both SHA and PCT to be abolished] But are a number of system players out there eg SHA CE and workforce directors, and CE and HR directors in some Trusts. And TM has become part of the language. So I am cautiously optimistic that this won't be an initiative that will just die out, but very much David Nicholson's baby at the moment, so what happens with the next CE?" (J)

7 National Survey

7.1 Introduction

A questionnaire survey of NHS managers in England was undertaken to provide the 'breadth' component to 'depth' of cohort interviews of Chapter 8. It examines qualifications, development programmes/activities, facilitators and barriers, and awareness of the TM programme.

7.2 Method

Our strategy was to aim for a purposive sample through the use of a range of databases. To the best of our knowledge no satisfactory comprehensive sampling frame of NHS managers exists, unlike, for example, the Medical Register for practising doctors. Consequently we have used three data sources to generate the survey sample:

- the Institute of Healthcare Management (IHM) kindly agreed to place a request to participate in their Newsletter which is circulated to some 5,000 members in England;
- a purchased 'e-shot' from Binley's® Directory of NHS Management database was sent to around 15,000 NHS manager email addresses in England; and
- 606 NHS managers in England in the HSMC data base of 'friends' and 'alumni' were emailed.

This resulted in a sample of around 15,000 NHS managers in England who were contacted to participate.

All managers in the sample were given further information about the project including a link to a summary of the project held on the HSMC website, and the link to access the survey. The project Consent Form was incorporated into the survey. The questionnaire (Appendix 4) was based on the interview schedule we had developed for the cohort interviews (see Chapter 8) in order to allow a degree of comparability between the two types of data. We purchased a license to use the on-line survey provider Survey Methods® ⁽¹⁵⁴⁾

The survey questionnaire was piloted within HSMC, enlisting the help of academic staff who had previously worked in the NHS. The robustness of the range of questions being asked and that of the survey software itself were confirmed during this piloting stage. The survey was open to respondents between July 2010 and the end of September 2010.

The completed survey responses were downloaded and imported into IBM SPSS Statistics 18[®] software for data cleaning and analysis. Analysis included basic frequencies, cross-tabulations and chi-square significance testing. The text responses were independently reviewed by two members of the project team to identify the main themes presented in the analysis that follows.

7.3 Survey Responses

We received a total of 604 responses to the survey: 51 from the HSMC database of 'friends' and 'alumni'; 40 from the IHM Newsletter; and 527 Binley's database. However, 24 were removed because they did not give full consent to the survey and 2 were removed because they did not give an NHS employment start date, which meant that they could not be placed in a cohort. For the main analysis, we also removed 5 who were retired or not currently working, and a further 17 who were currently working outside the NHS in England. This gave 556 responses which equated to a response rate of 3.7%, and amounting to about a 1.2% sample of the nearly 45,000 NHS managers⁽¹⁵⁵⁾.

7.4 Survey Representativeness

We compared our sample to the best evidence of the 'population' of NHS managers^{(155); (156); (157)} - Table 5. Our sample roughly corresponds to the population in terms of gender, ethnicity, age, and organisational type, but has fewer respondents with clinical qualifications.

Table 5. Characteristics of survey respondents

	Survey		NHS Managers
Gender (% female)		67%	59%
Ethnicity (% BME)		6%	7%
Age	Under 40:	26%	30%
	41-49:	44%	39%
	50 and over:	30%	31%
% Clinical		34%	50%
% Organisational Type	Trusts:	50%	54%
	PCT:	38%	35%

In terms of our cohorts, some 23% respondents joined the NHS before 1983, compared to 20% between 1983-89, 21% between 1990-97, and 35% in the period since then. Some 18% had one post during their NHS career, while 17% had 10 or more posts. In cumulative terms, about half of our sample had five or fewer posts. About 39% had worked in a management role outside the NHS, while about 35% had clinical qualifications. Our sample appeared to be well qualified. Some 43% had National Vocational Qualifications (NVQ) or other vocational qualifications; 72% had a first degree, while 56% had higher degrees (percentages add to over 100% due to multiple qualifications). There were some different patterns of qualifications between males and females. Of the males, 76% had a first degree, 51% had a higher degree and 26% had clinical qualifications. For females, the figures were 70%, 58% and 38% respectively, while the corresponding figures for BME staff were 63%, 59% and 44%. There was some relationship between qualifications and age. For those aged 21-40 years, 83% had a first degree, 56% had a higher degree and 22% had clinical qualifications, while the proportions for those aged 51-65 were 62%, 51% and 36%. This suggests that while the younger group may be better qualified (in terms of a first degree), a lower proportion have clinical qualifications. This was confirmed by the cohorts. The proportions with clinical qualifications were 39% for those joining before 1983, 29% for 1983-89 joiners, 19% for 1990-97 joiners, and 13% for those who joined after 1997. It is possible that this may relate to a 'traditional' route of clinicians (especially nurses) becoming managers may be giving way to a more direct managerial route, which has implications for clinical leadership. Of CE and Directors, 78% had a first degree, 71% had a higher degree and 33% had clinical qualifications, compared to the figures for other managers of 71%, 52%, and 35%. Considering that CE and Directors tended to come from the older age groups that tended to have fewer qualifications, the higher qualifications of the CE and Directors suggest the importance of qualifications in achieving these levels.

About 18% of our sample were CEs or Directors, including about 25% of males, 15% of females, and 19% BME. As expected, the percentage of CE and Directors broadly increased with age from 7% for those aged 30 or under to 45% of those aged 61-65.

7.5 Other Characteristics of Our Respondents

Some 38% females, 42% males and 44% BME previously had management roles outside the NHS. There were some clear relationships. Those with clinical qualifications tended to have fewer management roles outside the NHS (22%). Some 22% of the pre-1983 cohort compared to 62% of the post-1997 cohort had management roles outside the NHS. As expected, more females (32%) than males (10%) had career breaks.

Some 84% had undertaken professional management programmes/ activities. The most attended categorised activities included: short courses (48%), action learning sets (45%), mentoring (40%), coaching (38%), international management programmes (25%), senior management programme (24%), secondment with a training/stretching remit (18%) and NGMTS (11%). There was also a large number of unclassified/ 'other' activities which included project management training (PRINCE2) and post-graduate certification in a range of management activities.

7.6 Limitations of Survey Method

The main aim of the survey was to discover some basic quantitative information on TM in the NHS, although the 'free text responses' also added valuable qualitative information.

The two main problems of the survey were representativeness and low response. As mentioned above, it is difficult to establish the 'population' from which to sample. The King's Fund Commission on Leadership and Management points out that there is little information about who managers are, what they do and what their impact is.⁽¹⁴⁾ Walshe and Smith open their report with the words:⁽¹⁵⁸⁾

'We know remarkably little about the NHS management workforce-how many managers there are and what they do; who they are and where they come from; what training or educational backgrounds they have and how much that prepares them for management; how they come to work in management roles and what place this has on their career; and how their management careers progress or develop over time.' (p. 5)

Our study is an exploratory attempt to fill some of these gaps, but in the absence of clear population characteristics, it is difficult to determine that our sample was representative. Our sample was roughly representative in terms of age, gender, ethnicity and organisational type (above), but without the relevant population data, it is impossible to determine whether it was representative in terms of experience of development activities, let alone values or opinions relevant to development.

The second problem is concerned with possible bias associated with low response rate. As reported above, we had 556 responses which equated to a response rate of 3.7%, and amounting to about a 1.2% sample of the nearly 45,000 NHS managers. While this is a low response rate, it yielded sufficient responses for basic quantitative analyses for the total sample and for sub-groups (such as men and women). Moreover, while there was no obvious bias in terms of response rate from demographic groups, it is

possible (indeed, almost inevitable) that the sample is biased in terms of interest in TM and in responding to surveys.

7.7 TM and Professional Development

A higher proportion of males than females had attended most of the activities, although most differences were not large. For example, some 27% males had attended a 'senior management programme' compared to 23% females. The largest proportionate differences were for NGMTS (14% and 9%), ACE (6% and 1%) and AD (12% to 8%). A slightly higher percentage of females listed 'Clinical Leadership Fellowship' (3% to 1%), international management programme (27% to 21%), ALS (46% to 43%), with similar figures for coaching, mentoring and secondment. There was no clear pattern for ethnicity with similar rates for some activities such as international management programme and ALS, higher rates for white staff for NGMTS (12% to 0%), ACE (2% to 0%), AD (10% to 4%), and higher rates for BME staff for BT (17% to 1%), senior management programme (33% to 24%), coaching (54% to 27%), mentoring (54% to 38%), secondments (29% to 17%) and short courses (63% to 47%). There were some mixed patterns by age, with older staff (51-65) having undertaken more activities than younger staff (21-40) in some categories such as senior management programme (29% to 15%), international management programme (33% to 17%). On the other hand, a higher proportion of younger staff had undertaken NGMTS (22% to 6%), and clinical leadership fellowships (4% to 2%). There was no clear 'age gradient' for activities such as coaching and mentoring. These findings were broadly supported by analysis of the cohorts. For example, the figures for international management programme are 33%, 27%, 22% and 20% from the pre-1983 through to the post-1997 cohort. CE and Directors had undertaken more activity for all categories apart from international management programme compared to other staff. While this might be expected for courses such as ACE (13% to 0%) and AD (17% to 7%), it also occurred for coaching (55% to 34%), mentoring (49% to 38%), secondments (23% to 17%) and ALS (53% to 43%). As there are few clear and strong gradients by age or gender for these activities, it does appear that coaching, mentoring, secondments, and ALS are associated directly with being a CE/Director, although that does not indicate causality.

The main facilitators that enabled staff to pursue development opportunities were in order of incidence self-motivation (63%), support from line manager and senior managers (44%), opportunistic availability (24%), support of family (13%), support of peers (10%) and PDPs arising from appraisals (4%). There were no statistically significant associations between facilitators and dimensions such as gender, age and ethnicity.

About 95% of those who had been on programmes/activities stated that they were of value. The proportions reporting that programmes were of value did not vary by gender, and only slightly by ethnicity (96% BME and 95% white), age (97%, 21-40 and 93%, 41-50), cohort (97%, pre-1983 and 1990-97 and 92%, post-1997), and seniority (97% CE and Directors and 94% other staff). There was a little more variation by organisational type, which ranged from 100% for ambulance staff to 87% for Community Trust staff. A variety of benefits were given, including new skills, networking, confidence, wider perspectives, self-reflection, career progression, credibility; CV:

"It gave me confidence to apply for a role in x for which I was successful."

"All provide good networking links."

"Took me 'out of my box' and 'out of my comfort zone'."

"Introduced me to alternative thinking."

"Credibility with others through having a formal qualification."

"I now have a formal qualification ... which I can add to my CV."

A small number pointed to some shortcomings. A few people claimed that the course content was low level or not useful. Others pointed to lack of worth or impact in the sense that they had not led to career progression:

"Did not add or learn anything new or useful."

"I do not think they really developed my skills or abilities."

"Unable to convert into action in the workplace."

"They do not seem to have had any particular impact. They do not appear to have opened any opportunities..."

"As they were not nationally recognised they had no real value to future employers."

About two thirds of respondents gave some response on what additional elements would have helped them develop their NHS careers. Some pointed to individual elements or modules such as finance, strategic planning, operations management, and project management. Some stated that they wished to access existing courses such as ACE or AD, and some wished that existing courses had been available earlier:

"It would have been very useful to have access to some of the schemes which are available now a few years ago."

"The initiatives now in place would have helped me when I started out in 1975."

However, it was claimed that not all were aware of opportunities. Moreover, some expressed views that access to such courses was sometimes not open and transparent:

"There are some good existing schemes available. It is more a question of employers making their staff aware of the schemes and encouraging staff to apply."

"They could provide information to ALL staff about the programmes that are already in place so that anyone can have access to them."

"A consistent approach to personal development which is equitable across all NHS organisations and regardless of what financial pressures are experienced."

"There is definitely an 'in crowd' and an 'out crowd' operating in the NHS."

"It seems to me that it is a closed circle."

"Nepotism is the order of the day in being promoted."

Many pointed to coaching, mentoring, shadowing and secondments. A few suggested that a 'buddy' scheme for new managers in their first 100 days would be useful. One person pointed to the need for a continuous learning culture:

"Opportunity for secondment. I was told that if I wanted a secondment, not to come back!"

"Access to real stretch assignments/sabbaticals."

"I think shadowing senior managers as a key activity would have been useful ... managers are often left to sink or swim."

"I would value a mentor especially as I have recently moved to a new post and different city."

"Access to coaching or mentoring. More frequent shared learning such as ALS."

"A better continuous learning culture... I hear a lot of people say that they were sent on the course, enjoyed it while they were there ... but became despondent 'post the course' because the things they now knew needed changing or improving ... they couldn't get done because their boss/ organisation hadn't moved with them".

Of the 90 people who had not undertaken programmes/activities, 81% had considered undertaking it but 'constraint' factors prevented them taking it up. The main reasons were due to time (58%) and funding (27%), and lack of line manager (LM) or organisational support (22%). Again, there were no statistically significant associations between constraints and dimensions such as age, gender and ethnicity. Although not statistically significant, men and white staff reported more time barriers; BME staff reported more funding barriers; and men reported more support barriers:

"Every organisation refused to support me with either time or money."

"No time and no funding."

"Too busy with day job."

The remaining 19% broadly represented 'choice':

"Intending to take early retirement within 2 years."

"Because I simply want to live long enough to retire."

"I do not wish to take on more management responsibilities than I have at present."

"Extensive development prior to joining the NHS."

"There have been no circumstances to prevent me. I need to look into this."

There were some variations in the groups that stressed constraint rather than choice factors: 86% of females compared to 73% of males; 100% for BME staff and 76% for white staff, and 86% for those aged 21-40, 79% for 41-50 and 78% for those 51 and over, 67% for the pre-1983 cohort and 87% for the post-1997 cohort. Some 73% of the group with clinical qualifications had considered management activities compared to 91% of the group with vocational qualifications. Low total numbers makes some of the organisational type figures problematic, but 100% of ambulance, Community Trust and SHA staff stressed constraints compared to 58% of Mental Health Trust (MHT) staff.

Some 170 respondents (37%) reported problems either obtaining training or problems on training. There was only one statistically significant association: 40% of females reported that they faced barriers compared to 30% of males. However, there were some other variations, with 46% BME staff reported barriers compared to 35% of white staff, and fewer CE and Directors (32%) reported barriers compared to 38% of other staff. The proportion reporting barriers varied by organisational type, ranging from 17% of ambulance staff (from a low total) and 21% of MHT staff to 44% for both PCTs and Community There was no clear association with age or cohort. Trusts and 54% of SHA staff (from a low total). Of the 170 respondents who reported barriers, some 104 respondents (about 61%) had problems obtaining training, with the main issues being time (52% of the 104), funding (41%), workload (40%), and LM or organisational support (29%). There was only one statistically significant association (younger staff

reported more workload issues), but men and white staff reported more time issues:

"New CE less supportive of professional senior leadership."

"Absolutely no awareness of more recent leadership training opportunities."

"Senior manager ... querying relevance and cost."

"Sometimes having a line manager who did not understand the benefits to the organisation."

"ALS have been dismissed by line manager as a jolly."

"We say we are committed to training, but as soon as there is a cost implication you come up against a barrier."

"I have had to fight for every course I have been on, despite repeatedly being told I have the potential and the ability to achieve and succeed in senior management roles."

Some 82 respondents (48% of the 170) reported problems during their training. A small group (4%) reported problems both obtaining training and during it. The main issues for the 82 respondents were time (71%), workload (56%), LM or organisational support (20%) and funding (17%). There was only one statistically significant association (38% men reported lack of LM or organisational support compared to 12% women):

" All activities done in my own time."

"I had to take annual leave to facilitate attendance."

"It is difficult to undertake training whilst maintaining your 'eye on the ball' with your day job."

"Expected to carry on working full time and achieve all the targets Promised dedicated time never occurred."

Just over a third (36%) were aware of the current TM initiative in the NHS, although some who were 'not aware' had attended SHA courses such as AD. There were small differences in awareness of TM between male (39%) and female (35%) staff, and 34% BME and 36% white staff. There were larger differences in terms of age, varying from 31% for those aged 21-40 to 39% for those aged 41-50, and in terms of cohort, varying from 30% (post 1997) to 45% (1983-89). There was a substantive difference in terms of seniority, with 58% of CE and Directors being aware compared to 31% of other staff. Similarly, 25% of ambulance staff and 28% of MHT staff were aware compared to 44% of Community Trust staff and 57% of SHA staff. About a third of FT acute staff (32%) were aware. While this was a little lower than acute trusts (39%) and PCTs (38%), it did not indicate the level of disengagement that some of the interviews (Chapters 5 and 8) suggested. The group that were aware of TM pointed to some strengths in terms of better identification of talent, and succession planning:

"First time NHS has taken a proactive and systematic approach to development."

"Allows talent at all levels to be recognised and supported- good for employers and employees."

"Identifies future leaders."

"Enables good succession planning and should keep the best within the NHS."

However, others pointed to its shortcomings. Some saw potential advantages, but were unconvinced by details and by implementation:

"Badly implemented and only paid lip service by executive level."

"Can become too targeted at senior and very senior managers."

"Could be exclusive ... if not handled right."

"Fast tracking of talented individuals can cause resentment amongst peers."

"It can generate false expectations."

"The initiative is not widely known about or understood."

"The national and regional programmes do not link well, for example where does Gateway fit with ACE?"

"It doesn't work. Identification of talent is very hit and miss with no re criteria. The selection process seems to lack clarity and will produce clones of the current leadership – and it's failings... Feedback ... of recent very senior management courses is that they are expensive jollies."

Others had more fundamental criticisms of principle, or were cynical that it would continue, or even legitimate, the 'club' principles of the NHS:

"Elitism and further perpetuation of the old boys network."

"It is ageist, sexist, racist and all about who likes you because you flatter senior managers and look and act like them."

"It is totally subjective and likely to lead to greater ageism, sexism, racism and favouritism in the NHS."

"Lack of transparency in selection of the talent pools; for example Top Leaders led to suspicion and resentment."

"Glass ceilings are alive and well in the NHS."

A variety of improvements were suggested, including a more inclusive, objective and transparent approach. Many wished to see universal accessibility and self-nomination for courses (although this may increase the gap between supply and demand). However, many respondents stated that they did not have sufficient knowledge of the initiative in order to form a considered view, and some feared that the current financial climate and reorganisation might marginalise the initiative. Finally, some considered that TM needs to go hand in hand with a more robust defence of NHS managers (cf NHS Confederation 2007⁽¹⁵⁶⁾):

"All the benefits of TM in terms of organisational memory ... will be lost as SHAs and PCTs are disbanded. We all have to start again."

"Following the publication of 'Equity and Excellence'... I just hope that we don't lose a lot of the talent."

"In the next five years there will be a talent drain from the NHS."

"Given the recent White Paper and the spate of manager bashing I am very pessimistic as to the future of general management in the NHS."

"As well as TM, the NHS needs to work on the portrayal of NHS managers generally. We are often seen as scapegoats and overpaid bureaucrats in the public eye."

"I only wish that somehow the perception of NHS management could be drastically improved."

7.8 Conclusions

Our survey showed that NHS managers constitute a highly qualified workforce, with a high level of degrees and higher degrees, and some 84% had undertaken professional management programmes/activities. The main facilitators that enabled staff to pursue development opportunities were in order of incidence self-motivation, support from line manager and senior managers and PDPs arising from appraisals. About 95% of those who had been on programmes/activities stated that they were of value. A variety of benefits were given, including new skills, networking, confidence, wider perspectives, self-reflection, career progression, credibility and CV. A small number pointed to some shortcomings, with a few claiming that the course content was low level or not useful, while others pointed to lack of worth or impact in the sense that they had not led to career progression.

About two thirds of respondents gave some response on what additional elements would have helped them develop their NHS careers. Some pointed to individual elements or modules, while others stated that they wished to access existing courses such as ACE or AD, and coaching, mentoring, shadowing and secondments. It was clear that not all were aware of opportunities, and some claimed that access to such courses was sometimes not open and transparent.

Of the 90 people who had not undertaken programmes/activities, 81% reported that 'constraint' factors prevented them taking it up, with the main reasons being time and funding. The remaining 19% broadly represented 'choice' factors such as having previous development experience or being too close to retirement. Some 37% stated that they had experienced some barriers or obstacles in obtaining chosen training or once on the programme or activity. The main barriers to accessing development were seen as time, funding, workload and lack of organisational support. Once on the course, the main barrier was seen as lack of dedicated study time, leading to people trying to juggle work, study and home commitments.

Just over a third were aware of the current TM initiative in the NHS. This group pointed to some strengths in terms of better identification of talent, succession planning. However, others pointed to its shortcomings. Some saw potential advantages, but were unconvinced by details and by implementation. Others had more fundamental criticisms of principle, or were cynical that it would continue, or even legitimate, the 'club' principles of the NHS. A variety of improvements were suggested, including a more inclusive, objective and transparent approach. Some feared that the current financial climate and reorganisation might marginalise the initiative. Finally, some considered that TM needs to go hand in hand with a more robust defence of NHS managers.

8 Cohort Interviews

8.1 Introduction

The 'cohort interviews' were based on the four cohorts of the previous work of Exworthy and Macfarlane⁽⁹⁴⁾. The cohorts are defined as those who entered the NHS:

- before 'Griffiths' (before 1983)
- during the 'general management period' (1983-1989);
- during the 'quasi-market' phase (1990-1997); and
- during the New Labour collaborative market period (1997-2010).

The cohort interviews are intended to provide the 'depth' element to complement the 'breadth' of the survey (Chapter 7).

8.2 Method

As with the stakeholder and SHA interviews, the first tranche of potential candidates were identified from the expertise, knowledge and contacts of members of the project team. Our aim was to produce a response sample of around 60 managers and to ensure we covered potential differences by gender, ethnicity, age, seniority, NHS organisation, region and cohort. Subsequent potential candidates were identified through 'snowballing' the original tranche of respondents by asking if they could recommend appropriate managers who might be willing to be interviewed.

A total of 42 interviews were completed. Data analysis was on-going throughout the project. Interview transcripts were reviewed independently by two members of the project team as they became available. The aim was to identify key themes and issues that emerged from the data. Both agreed that at around the 40 interview mark no new themes were emerging from the data and therefore it was judged that data saturation, where further sampling does not reveal new ideas from additional participants had been reached⁽¹⁵³⁾ and, therefore, no further interviews were arranged.

All respondents were contacted by email, which provided details about this stage of the project and what would be expected of respondents, and stressed the confidentiality of the responses given. A copy of the project summary and a participant information sheet were attached (Appendix 5). All interviews were conducted by telephone, and with the permission of

respondents, all interviews were digitally recorded (with one exception) and subsequently transcribed. Completion of project Consent Forms was requested at the time of interview. The interviews took place between mid-April 2010 and mid-July 2010.

The interview schedule (Appendix 5) was derived from our findings from the literature review, focus group sessions and insights provided by the stakeholder and SHA interviews. It was piloted with the first half-dozen respondents who were well known to project team members and who had kindly agreed to provide comments on the usefulness and appropriateness of the questions being asked. The main areas covered during the interview included:

- details of career history;
- details of managerial professional development history;
- factors that influenced take of professional development opportunities;
- facilitators / barriers to uptake of professional development opportunities;
- if professional development has supported development of career;
- values, beliefs and motivations for working in the NHS;
- awareness of TM; and
- future career plans.

8.2.1.1 Limitations of Cohort Interview Method

There are two main problems with the cohort interviews. First, the total number of interviews is fairly low. While we feel that the total number of interviews is sufficient in terms of saturation, there are low numbers in some categories such as SHA area. Second, there is some possible response bias in that our initial interviewees were selected from personal contacts. While subsequent 'snowballing' may have reduced any selection effect, it is possible that people willing to be interviewed might not have 'typical' views on TM. However, as pointed out earlier, we did not aim for statistical generalisation.

8.3 Cohort Interviews: Main Themes

8.3.1.1 Entry to / Exit from the NHS

This section examines entry routes into the NHS and, where relevant, exit routes from the NHS. There were three main routes into NHS management posts:

- direct (entry to the NHS as first job);
- clinical (moves from clinician to manager); and
- indirect (entry from outside the NHS).

Entry was roughly equally divided between the three routes. The 'direct' route refers to those who entered as, depending on the time of entry, NHS managers or administrators. Some had worked in the NHS since the 1970s. Although many stressed that their values were compatible with the NHS (see later), few had a clear desire to work as a manager in the NHS. Many respondents' routes were more unplanned, and they joined 'by accident':

"It was the first offer that came in and I accepted it." (8)

"I did not wake up one morning and say I don't want to work for the NHS." (15)

A number of direct entrants came via the graduate training scheme, variously refereed to in the interviews as MTS/GTS/GMTS/NTS. Most considered that the schemes were good. In particular, the 'Cook's Tour' gave experience with different parts of the NHS:

"NTS is a valuable thing as moved around the different parts of the NHS. So I think that breadth of experience at the beginning was really good." (30)

The second main route includes those who had moved from a primarily clinical role to a primarily management role. Most were originally nurses, but there were a few doctors, paramedics, pharmacists and physiotherapists:

"The transition was partly 'pure serendipity'. Not a planned move, but 'incredibly uncomfortable'." (10)

"I sort of 'drifted' into management." (29)

Most doctors came through the Medical Director route, although it was noted that:

"Most medical CE have come via MD in own trust." (3)

The third route of indirect entry included a number of entry points including local government, and the private and voluntary sectors. A number had entered through the Gateway scheme. The scheme was generally considered to be very good:

"Gateway provided a brilliant opportunity." (12)

"I have taken 5 people off Gateway. With one exception, they have all been fantastic. I am a big fan of Gateway, which is an example of a national initiative I think has been very positive." (22)

A few had left the NHS, only to return later. For nurses, the main 'interim' post seemed to be the voluntary sector. Four had left the NHS. One could be classified as the result of 'pull' factors:

"Not a matter of money. I was already well paid. I mean, I couldn't believe the salary increase I got as a result of the 1974 reorganisation." (8)

Three appeared to be more the result to 'push' factors:

"Line manager was pretty awful, a bully, so I decided that enough was enough." (38)

"I left the NHS as recognised that my basic values and principles were at odds with the ones that I experienced when I went to work every day ... I experienced a whole range of behaviours ... some of which were frankly appalling. I witnessed the most appalling bullying of extremely capable and committed senior clinicians and managers. I did not wish to be part of system that is going to 'bash, trash, batter and bruise' people and chuck them out of the organisation. On a personal level, I never wish to work directly employed by the NHS again." (40)

8.3.1.2 Values

Many stressed that they were 'passionate about the NHS' and that 'making a difference' was important:

"There is part of me that still wants to save the world. I'm a, kind of, hardcore professional nurse, my values are about what the real NHS is about. I think it is an ethical way to earn a good income, as opposed to being an investment banker or an estate agent." (29)

"I've got a real public service ethic and I really believe in the NHS." (5)

Some gave more mixed responses, including practical 'pay the mortgage' responses:

"I get a buzz out of making things happen. And that often happens in the NHS." (18)

"Commitment to people of local area. Affinity with the place. I recognised that I did not feel the same about doing the job anywhere else. I will never go anywhere else." (11)

8.3.1.3 Working in the NHS

Four main themes surfaced here. First, although no one denigrated training and development activities, some considered that 'job experience' and 'learning by doing' suited them. It is important to be proactive, and in contrast to the conventional wisdom of National Service, people *should* volunteer for tasks:

"The advice I give people - doing things outside your comfort zone." (23)

"Most of it was self motivated. I did difficult jobs, project work, took on different roles, and volunteered for things outside normal work ... a huge portfolio. One of the reasons I stayed there was that I was getting more experience than I would by moving." (15)

Some felt that, with more CE posts in the systems, some CE lack the experience of previous periods:

"I was of a generation where the junior doctors worked 100 hours a week and so by the time they became consultants had had masses of experience and it was a bit like that with management at the time. We all kind of earned our stripes. ... Of course there were far fewer CE in the system then." (21)

"I was a director for 10 years before I was a CE so I had been round the block a hell of a lot." (35)

Second, some pointed out that a wide range of experience, and movement between sectors was good. However, it was felt that there was a hierarchy in the NHS, and it was better not to be 'stuck' in some sectors:

"It is more difficult to move around now. It is a bad thing that people have not got broad experience across the different sectors." (6)

"I've had this repeated time and time again - that if you are ambitious, do not stay in a job for more than 4 years." (14)

"People warned that leaving acute for MH could be the death of my career." (22)

Third, some stressed the problems of transition between clinical and managerial roles:

"I think one of the problems is that when you come through a clinical profession, a clinical professional route, you are heavily influenced by the culture and ethos of that profession I think that is why it is so hard for many people to break out, if you like, of their comfort zone that has been created by the profession that they have come through." (18)

Fourth, there was a feeling that some inside the 'club' were treated differently to those outside:

"I applied for post at x [unsuccessful] and subsequently found out that I completely wasted my time applying for it because a deal had already been done about who was getting the post." (29)

"At that time [Griffiths] promotion was very selective, you almost inevitably had to have been on the NMTS ... Sense of clique and elite." (6)

8.3.1.4 Pivotal people/moments in career transitions

Many point to a few supportive people, who were often role models. Pivotal people included those who were prepared to believe in someone and take a risk or a gamble. Many pointed to reorganisations as pivotal moments or events, with some regarding reorganisations as a way to lose good people:

"Pivotal moments have been prompted in part by NHS organisational change. [I was] proactive [in getting a new job] as HA being abolished." (1)

"[Reorganisations did] not get rid of those who should go but those who are easier." (32)

8.3.1.5 Barriers

Many said that they had not faced any significant barriers. One of the few general barriers or obstacles mentioned were the juggling of work, study and life balance:

"The only stumbling block is juggling programme with workload." (14)

Most of our female and BME respondents stated that they had faced no significant barriers. However, there may be something of a selection effect in that those who had risen may have been those who faced fewer barriers:

"No barriers- absolutely not. As a woman in the service for 30 years I'm afraid I've never seen this concept of a glass ceiling. To be quite frank, I've always viewed being in a minority as a distinct advantage. When people started to go for positive discrimination I found that personally quite difficult because I'd never wanted to be the token person there." (21)

"No barriers. I can honestly say that I personally don't think I have faced any form of discrimination at all anywhere." (BME, M)

However, a few in these groups did point to some barriers:

"Some individuals felt that some places were not the place for women managers." (F)

"Sometimes different treatment when meeting compared to email where they cannot tell who you are. So you start to ask yourself 'I wish I had an accent similar to others'." (BME, M)

However, a few pointed to the importance of being part of the 'in crowd':

"Just feeling that I was not on the list of people who were allowed to get X Director jobs in the NHS'... Conformity is more important than talent." (9)

8.3.1.6 Ambition/Next steps

Some respondents had very clear ambitions to be a Director or CE:

"Even from the first time I started in the NHS that one day I would want to be a CE." (17)

Others expressed a mix of less ambition and more realism:

"Given the age I am [mid 50s], I tend not to be particularly ambitious. I think you are more ambitious when you are younger but your values change over time; you can call that work-life balance if you like. I reached a point in my life where I had to put my family first before my career." (4)

"[Deputy CE- next move to CE?] That's what my CE says, but I am not sure I want that. I think I am a very good number 2 and I don't think there's anything wrong with being a good number 2. Aspects of CE are role not in my comfort zone." (1)

Some stated that they aimed to stay in the NHS, but others were less certain:

"In NHS for foreseeable future, but not necessarily until 65." (12)

Some considered that, in the recent uncertain period of reduction of management costs and reorganisation, the NHS might leave them.

"Would like to stay but circumstances may not let me." (10)

"Next stage normally Director [PCT AD] but I don't know given the current climate and may not be working in the NHS at all." (31)

8.3.1.7 Turnover/ attrition

It is sometimes suggested that one reason that managers do not wish to progress to being CE is because of the precarious nature of the post, with figures quoted of the average CE tenure of 700 days (Chapter 1). Most respondents recognised this, and regarded it as a problem to both the individuals concerned and to the organisations. However, some questioned these figures:

"The reason why is important - the majority may be career progression?" (14)

"PCT were reforming so it [the 700 days figure] can be people sort of staying in the same jobs, but moving around in terms of organisations; statistically a bit dodgy. Some organisations have fast turnover, so problems may be concentrated in particular places." (30)

Some pointed to largely structural or system reasons for this:

"Blame culture- one mistake and CE head must roll. No-blame culture of clinicians does not seem to apply to CE." (26)

"The NHS seems to chew up and spit out CE. You hit a point where it becomes much less about are you competent and more about does your face fit, does the DH need a human sacrifice, are you getting on with your chair, is the media hassling you? ... and you become the fall guy." (5)

A few pointed more to agency or individual factors. For example, more NHS organisations might mean that the supply of CE might not keep pace with demand: a variant of Kingsley Amis' famous comment that 'more will mean worse':

"High attrition rate because of the proliferation of NHS organisations." (12)

Some recognised both sets of factors:

"Quite a number of them deserve to go. There are a lot of people in these posts that are not well equipped to be in them and so inevitably the attrition rate is high. There are other situations where sometimes good people just find themselves in the wrong place at the wrong time and the system can let those people down." (21)

"Of all the CE that I know, I think a third are doing an outstanding job, a third are ok and a third can't do it and it may be that the attrition rate is in that third... David Nicolson is right when he says we have not got the right number and calibre of candidates and there are lots of reasons for that; and one of the reasons is that it is seen as being a fix all the time. [Interviewer: Even now?] Absolutely now." (35)

Some gave advice to choose posts carefully, and to be prepared: it should not come as a surprise that being a NHS CE is a tough job. It was stressed that not everyone was suited to be a CE:

"You need to be very resilient in order to survive as CE. You have to love the job for its own sake. One of the saddest people I knew was someone who thought she wanted to be a CE and actually hated it. We appoint people because they do a good job at Director level, they look like they have potential. But some not prepared for reality of post. So problems partly about the realism of people aspiring for

CE jobs and partly about the way the system behaves when things go wrong.” (24)

“Just because you are a good Director does not make you a good CE.” (11)

8.3.1.8 Development Activities and Courses

Our respondents had attended a wide variety of development activities. These ranged widely in provider (in house versus external; bespoke versus generic), length and level. Experience of courses was mixed. Some were regarded positively. However, to some extent, there may have been a selection effect:

“My experience of programmes is generally positive because I’m very fussy.” (24)

Other experiences were more negative or mixed:

“Some courses were a bit didactic and top down.” (26)

“An awful lot of money has been wasted on development over the years.” (21)

There was a feeling of ‘credentialism’ among some. In other words, courses were an ‘entry ticket’, and were more for CV purposes rather than any inherent benefit per se:

“You need a Masters for certain grades.” (25)

“If you wanted to progress, you needed a formal management qualification. You are not going to get very far unless you have got these tickets or bits of paper.” (29)

This can also devalue the experiential knowledge of other managers:

“I am still unqualified. I can easily demonstrate my experience and skills. I just don’t happen to have a first class degree.” (33)

“I cannot remember any formal training courses. I found myself always having to learn things for myself.” (8)

Some pointed to the difference between courses for ‘development’ and for career advancement:

"Courses have moved me on personally and professionally, but I do not think they have moved me on career-wise." (10)

"When I looked at MBA course that was the first time I thought 'I can see the course there that actually is going to benefit me in my job. It was different in the past. I was doing it to have something on my CV.'" (34)

Experience of recent National/SHA courses, including ones for aspirant directors (AD) were rather mixed:

"[AD course] I swam in that; really enjoyed it. I thought it was incredible. It taught me that I did have the talent and ability to become an executive in the NHS". (33)

"A lot of the content was certificate level stuff." (29)

"[AD course] first cohort in SHA and so we were the guinea pigs... . The actual programme was disappointing really." (34)

The 'Breaking Through' (BT) programme was generally very positively regarded:

"The best development course I have ever had'. BT gave me a massive confident boost. It was empowering and it changed my life." (7)

"Experience of programmes and activities was definitely positive. I think it has made a great impact on my career. In terms of coaching, mentoring, networks. BT is 'exceptional'." (17)

However, one respondent stated that:

"I want to progress because I can do the job, not because of my ethnic background. I said that I preferred AD to BT due to the 'level footing' but I now recognise need for such programmes." (14)

The few who mentioned Action Learning Sets found them very positive, but it is not fully clear whether the 'learning' or the networks were the key factor:

"Incredibly helpful. What I got out of my first LS was a lot of contacts and networking." (18)

Some stressed that you had to push (or make your own luck) in getting onto courses:

"It has not been difficult and I think sometimes it is about knowing the system and knowing who to speak to both to find things out, but sometimes to just get that foot in the door." (18)

However, others pointed to significant barriers:

"Nobody in my Trust had ever put me forward for anything. Early colleagues are now senior managers and they have been on opportunity after opportunity and I think the only difference is that they are white and I am BME. I have always had drive, but never been given the opportunities. I consider myself as good as other candidates who got posts." (BME, F)

"Lack of support ... career has regressed; no further forward." (BME, F)

The NHS was generally seen as encouraging and supportive. It paid for most of the courses, although a few people financed themselves, while there was cost sharing in other cases. This was not necessarily regarded as a problem:

"I had to pay for several development activities [eg part of Masters], which I don't think is the wrong thing. I think we put people through courses for courses sake with no personal commitment. I have sat with people who take the course as a matter of course rather than as a personal and professional development opportunity." (10)

While many people had some time off to attend courses, most respondents pointed to the problems of finding sufficient study time:

"No time release- degree has to fit in around my work." (2)

"[My MBA] was given a token 3 hours off a week." (29)

It is difficult to reach any consensus on which are the 'best' courses, because of the wide variety of courses and low numbers of respondents, and because 'one size may not fit all': some preferred features of a course (generic, mixing with non NHS managers) which conflicted with other preferred features (local NHS, bespoke). Some considered that the better

courses for them were 'externally focused', with some international experiences, and mixing with managers from outside the NHS. On the other hand, a few stressed the importance of local NHS courses because of the potential for networking.

8.3.1.9 Secondments/ stretch

Secondments were generally considered useful and those who had not had secondments generally wished that they had been offered them. Some pointed out that secondments in other parts of the NHS and in the private sector were useful, but there is some overlap with networking in that one value of secondment is 'just getting your name mentioned to the right people':

"[Acting up at CE] so I knew that I could do the job and that I enjoyed it." (11)

8.3.1.10 Coaching and Mentoring

Most stressed the importance of coaching and mentoring, although the difference between the two was not always clear, and for some 'informal mentoring' blended into 'networking' (below). The level of coaching and mentoring in earlier periods was not fully clear. While some respondents recalled the experience, others did not. Some of those who had not had a formal coach or mentor wished they had one. Coaching was seen as particularly important as times of reorganisation, and for new CE:

"I have used lots of people as informal mentors over the years." (3)

"I would have benefited from mentoring/coaching earlier in career." (13)

A few had more mixed views, with only one negative experience. The relationship between mentor and mentee was seen as important, with some relationships not working for some people. A few stated that they regarded an outside person as important:

"I have been semi actively looking for someone as a mentor. I have come to the conclusion that I really need to look outside the NHS for a mentor from the private sector." (29)

"I have had mentor arrangements with different level of usefulness. I think it's partly about knowing how to use them." (35)

"People may need more mentoring in times of organisational change. Need someone other than [one's] line manager to go to say 'I am struggling with this'." (38)

8.3.1.11 Networking

Networking was regarded as very important, although there did appear to be some negative connotations of exclusion. Many stated that they had been 'head hunted', 'set up' or 'tapped up', with the implication that some appointments were far from being open, fair and transparent:

"I personally think it's a case of if you are in the right place at the right time and you are fortunate, you're ok. [Career development] comes out through the networking opportunities far more than it comes through any strategic plans." (32)

"I always sort of felt there was a club that I was never quite part of." (30)

8.3.1.12 Appraisals

The appraisal process was broadly viewed in negative terms in both quantitative and qualitative senses. Some pointed out that appraisals often did not take place at all:

"I have not been appraised in 20 years. I had one many years ago that was bit of a damp squib." (21)

"My experience of the NHS is that there isn't really one [appraisal process]." (27)

It was broadly agreed that appraisals were beneficial in principle and there were some feeling that appraisals were getting better:

"I don't really think that in my early years [early 1980s] there were things like annual appraisal or kind of development reviews or anything like that." (35)

"Appraisals have got better over past 5 or 6 years. More detailed and more honest." (18)

"We have a new Director of Operations who has 'politely gone slightly ballistic at our very poor appraisal rate'. You need someone at the very top, not just the HR Director banging the drum." (32)

However, the majority view was that where appraisals did take place, their value was often seen as limited. However, 'mixed' experiences suggest that there are some good appraisal systems and appraisers, and 360 degree appraisal was generally seen as beneficial:

"We are performance managed on the number of staff that have appraisals every year and so there can be a surge to get these done in time; sometimes empty and rather tokenistic, going through the motions, can make appraisee devalued." (25)

"Most chairs do not have the skills or training to appraise. Perfunctory would be an exaggeration of the discussion about development. So CE need to get that for themselves from somewhere else." (CE, 35)

"I have a real mixed bag of being appraised. At one end of spectrum, I have had genuine regard and interest and real appreciation. At other end - yeah, you're doing fine and sign down there. I have also had appraisals fixed and then cancelled, postponed, cancelled and postponed. Need to take it seriously." (1)

"Experience of 360 degree assessment was good, very reaffirming." (34)

Some suggested that regular, informal 'appraisals' were better:

"I am not a great proponent of the formal appraisal process for my executive team because I constantly appraise them. I do it all the time, that's how I manage. You need an open culture, based on continuous learning and feedback." (21)

"I think that as I have got more senior I have found appraisal to become more superficial. Because you are talking to appraisers all the time, so setting aside a couple of hours once a year to do a form appraisal feels a bit like ticking boxes. Often a pretty superficial conversation." (16)

8.3.1.13 mt and Talent Management

This section explores experiences of the earlier 'mt' system and the current 'Talent Management' system. Some recalled 'mt' initiatives. These contained

many similar elements, but they tended to be rather ad hoc and variable, and there was little in the way of a joined up system:

"The system was broadly supportive, but it was more ad hoc and informal rather than structured or planned." (1)

"[Worked in NHS HR in late 1970s] I cannot remember anything very proactive around 'TM'... mainly reactive and passive." (8)

It was generally felt that TM systems were good in principle and were needed in the NHS, but knowledge of it tended to be fairly limited:

"Current TM is long overdue." (18)

"Although interested in TM, I have limited awareness of NHS TM." (27)

Some considered that the private sector led the way in TM:

"Private company managed their talent really well....talent register 'like an escalator'; you're flagged as talented then you're on the radar and when jobs come up they pick from that pool. They get rid of dead wood; if you're a poor performer you are managed out of the organisation." (27)

"ICI- they have really robust succession planning, so that any time they will know from their employees all over the world who are the sort of rising stars, who are destined for the next top jobs. And I think the NHS has always been a bit schizophrenic about doing that, versus equal opportunities for all." (19)

On the other hand, some stressed that the public sector may be fairer than the private sector:

"There were lots of obstacles in the UK banking industry... the public sector was far more friendly and welcoming." (BME, F)

It was sometimes considered that the NHS was more tolerant of poor performance, and that 'honest conversations' were often lacking:

"I think that the NHS hangs on to some people who are just not worth hanging on to." (37)

Many felt that the NHS had made some progress on its TM journey, but it was still early days, and that the impact of TM was very variable between and within SHAs:

"Only just starting. We have moved a long way in the last couple of years but it's still relatively early days." (3)

"Still not structured, systematic, varies by SHA, ad hoc; need to be in right place at right time." (25)

"I think that TM is a really good idea. Some of the underpinning theory I think is terrific, but I think there's a real danger that we are going to balls up the implementation because we are confusing too many things." (22)

Whatever structure or 'system' is in place, its impact will vary due to 'agency' reasons, that managers and staff will vary in capacity, skills and motivations:

"TM can get marginalised. It depends on the way individual managers and leaders work with their staff." (38)

"It depends on who your boss is and what their motivations and interests are." (41)

There were varied views about individual elements on the TM initiative, particularly the Top Leaders Programme (TLP) (although perceptions of the numbers involved varied) due to reasons of selection and transparency, and the effect on the morale of those not chosen:

"TLP has caused no end of consternation. It feels wrong in the NHS to lot of people. There's a lot of suspicion that it's about who you know rather than about genuine talent." (3)

"TLP through three dramatically different routes. One is the most challenged organisations whose teams have been entered as a whole. If I look around [X SHA] one of the reasons at least two of them are the most challenging is because the people running them are no bloody good. So there's a collection of people there that actually you wouldn't think of as the Top Leaders of the future necessarily. Then there's a group of people who - because we are painting by numbers again, so they have asked the finance function, IT, nurses to identify their top people, so you have got a complete

mish-mash there. No great coherence or consistency there. Another group identified by SHA CE as being, like me, I guess, modestly, at the top or near the top of their game. It is an extraordinary mixture of people. It did not make any sense in the end; need differentiated approach. The selection process is flawed.” (22)

“Bemused by top 500. I still do not know what that means. I do not think there was a plan that was applied systematically across the regions... People not on list get upset. Inconsistent. If you look at the list, you can think of people who are equal.” (15)

“I did not go to launch but when people came back I said well what is the programme and nobody could really be specific about that. I think the general sense is a sort of sense of bemusement really. Selecting whole teams of challenged organisations was hugely controversial. There are obviously really good people in other organisations doing really good jobs who are not going to get a look in. Some SHAs put everybody in, but if everyone had done that it would have been too large a number.” (30)

There were concerns that the NHS was too slow on its inclusion agenda:

“I think David Nicholson is right to be impatient about inclusion. I don’t think we have moved anywhere near fast enough on that.” (18)

“The NHS recognises in theory, but I’m still not sure whether it recognises in practice, the value of diversity in its leadership community.....I think you’ll find the further away you get from London the whiter and more male it becomes.” (24)

“Inclusion element very good, but some people nervous of joining it as it is perceived as positive discrimination.” (13)

“I am not sure we are making enough efforts to increase the number of very senior managers who come from a clinical background. You could count on the fingers of one hand probably the number of CE who have come from a medical background. I think I have benefited hugely in my career from my clinical background. The advantage the doctors have is that if it all goes pear shaped at the end of the day you can go back to being a doctor

again. That does not apply to the rest, and if you fail as a CE it's a long way down." (16)

There were a few concerns about the impact of TM, and how the elements fitted together:

"So how many CE are saying to their Directors: actually let's be honest you are never going to be a CE so why would you want to go on this programme'. A small PCT CE post became vacant, ideal for a first timer, but despite over 17 eligible or 'ready now' people in region, they ended up advertising and getting someone from outside the region." (3)

"I do not think TM will come to much....tokenism, patronage and cliques are the dominant cultural decisions. I was shortlisted for a specialist post, but it went to someone else who did not have specialist knowledge but was actually a mate of the CE and they had worked together in a previous organisation." (29)

"TM very much geared to around BME and female staff. I don't feel it is an even handed approach in this area, which is slightly disappointing for me as a white middle class male." (4)

"We have to submit TM plans. I don't know that it was terribly useful. It should have been and it could have been but it just somehow wasn't. It just got caught up in bureaucracy and form filling and tick boxing. We do something and then a few months later there's a central or regional dictat that says you must do x, y and z but we may have done it already but in a different format It can lead to organisations not wanting to be very proactive because what is the point of getting on with it when you are going to be told in the future to do it." (41)

"I suspect this is a minority view, but the NHS has to make a decision one way or the other because they are trying to ride two horses at the moment - to be fair and open to all, or to develop the top level." (10)

There were some concerns about the future of TM, given that previous initiatives have not been sustained, and the competition for resources in a more austere funding era:

"I have seen for a number of years attempts to establish succession planning, talent pools to really get to grips with leadership development and I haven't really seen it working systematically yet. At the moment the jury is out. I think leadership development has become flavour of the month and I'm pleased it has because I believe very strongly in developing talent. But I'm not sure whether or not it's actually going to lead in the end to the results that have been talked about." (16)

"The problem of turning on and off the tap...it is difficult to plan our TM and career pathways." (32)

"There have been lots of attempts to have an overall approach but none of them endure. Whereas if you look at Tesco or BP, they have development programmes that change and adapt but have been going for years. And just about the only thing that has been going for years has been the NTS." (22)

"What happens to TM now? I'm not saying TM strategies are dead in the water, but we are going to lose a hell of a lot of talent." (31)

"We have a complete freeze on training at the moment. It is one of the first things to fall away when the money gets tight." (41)

8.4 Conclusion

A number of issues appear to underpin many of the above themes. First, it is generally considered that the current TM system has the potential to correct many of the problems in the old mt 'system'. However, some consider that it will be difficult to change the 'old' ways of the 'club' system. Some see some tensions between 'talent spotting' and open, fair and transparent systems. Moreover, the impact of any 'system' is unclear, given that it depends on the capacity, skills and motivations of individual managers and staff. Finally, the future of TM in future austerity is unclear.

9 Talent Management in High Performing Trusts

9.1 Introduction

This chapter explores the link between TM and organisational performance. We begin by reviewing some of the literature in the area. Then we explore results from the 2009 NHS Staff Survey, before presenting findings from our interviews with a range of 'high performing trusts' (HPTs). This should give some information on whether TM in high performing Trusts is different to the national picture. First, we will outline the methods used to undertake the field work at the HPTs.

9.2 High Performing Trusts - Method

We selected five HPTs representing different organisational forms (Foundation Trust; non-FT Acute Provider Trust (APT); Mental Health Trust; Primary Care Trust; and Ambulance Trust (AT)). Selection for contact for inclusion in the research was based on Trusts which had achieved 'excellent' or 'good' ratings on the financial management score and overall quality score of the Care Quality Commission's (CQC) *NHS Performance Ratings*⁽¹⁵⁹⁾ for the three years 2006-07, 2007-08, 2008-09. These were the most current ratings available to us at the time of selection. A small number of acute Trusts were excluded from this selection because they had scored particularly poorly on the Dr Foster hospital rating system of 2009⁽¹⁶⁰⁾.

However, external factors led to two of the five organisations being dropped from parts of the analysis. First, at the time of recruitment, it had been announced that PCTs were to be abolished. Despite approaches to a number of high performing PCTs, their CE felt that it would not be appropriate to conduct work on TM in organisations where staff had major anxieties about their jobs. Second, at a late stage in protracted Research & Development / governance processes, the Trust stated that it would require a fee to take part in the research. As this was not part of the project budget, and as we did not wish to establish a precedent, we reluctantly dropped the FT from the analysis, and time would not permit the beginning of R&D/ governance processes at a substitute FT.

We have used our five selected Trusts and profiled them using the data from the NHS Staff survey. In order to retain anonymity of the Trusts we have not referenced the NHS Staff Survey data for individual Trusts.

Potential candidates for interview at each of our three Trusts were nominated by our representatives at the Trusts. They were asked to select a range of managers with various seniority and function, including one who could speak as a lead on the TM and leadership ethos and activity at the Trust. All managers contacted were provided with details about this stage of the research and what would be expected of them, and the confidentiality of responses was emphasised. They were supplied with copies of the project summary, participant information sheet, and completion of the project Consent Form was requested at the time of interview. All interviews were conducted by telephone, and with the permission of respondents the interviews were digitally recorded and subsequently transcribed. The interviews took place between the beginning of October 2010 and the end of January 2011.

The interview schedule was very similar to the one used for our cohort interviews (see Chapter 8 and Appendix 5), with the addition of a couple of questions on how important the Trust is perceived to take professional development of its staff, and how respondents believed this impacted on the success of the organisation. A series of questions were devised for the TM lead respondents to obtain information on the what the Trust were providing for their management staff and the importance of the role of professional development and TM (Appendix 6). Six interviews were completed at our Ambulance and Mental Health Trusts, and seven at our Acute Provider Trust.

All the transcribed audio recordings were reviewed independently by two members of the project team, to identify the main themes that are presented in the analysis that follows.

9.2.1.1 Limitations of HPT Method

As in much of social science research, determining causation was problematic. In addition to the inherent problems associated with determining causation, we lack clearly agreed measures of our 'independent variable' of TM (see Chapter 2). If this existed, we could have carried out a quantitative study with controls of whether good TM at time t0 was followed by good organisational performance at time t1. However, as we lack a good measure of TM, we undertook case study research to see if perceptions of good TM appear to be associated with good organisational performance. With a longer study period, we could have examined if perceptions of good TM at time t0 was associated with good performance at time t1. However, in a short study we had to examine whether high consistent current and recent performance was linked with TM (but do not imply – unlike the original McKinsey study- that our 'independent variable' of TM works backward in time to 'cause' earlier good performance in our 'dependent variable'.^{(3); (12)}

Further problems were experienced in being able to carry out interviews in only three of our five organisational types, and in the rather small number of interviews carried out for each case study. However, there did appear to be some saturation tendencies in the data collection, and there was some evidence of triangulation/cross checks in that the information collected from the staff broadly confirmed that collected from the TM Lead in each Trust.

9.3 TM and organisational performance - background

There is a significant literature around 'high commitment management' (HCM) and 'high performance work systems' (HPWS). In simple terms, this claims that there is a link between Human Resources Management (HRM) and organisational performance. Put another way, organisations can achieve competitive advantage through effective management of its staff. According to Michie and West⁽³⁷⁾ people and their performance are key to an organisation's effectiveness. Some major figures have argued this case. Collins⁽⁹⁾ argues the importance of 'getting the right people on the bus' (i.e. effective recruitment). Pfeffer⁽³⁸⁾ claims that HR practices build 'competitive advantage through people', while Pfeffer⁽³⁹⁾ outlines HR practices for 'building profits by putting people first'.

The link between HRM and organisational performance has been accepted within the NHS. For example the 2000 Improving Working Lives Standard⁽¹⁶¹⁾ stated that:

'... a modern NHS must offer employees a better deal in their working lives. Improving the working lives of employees contributes directly to a better patient care through improved recruitment and retention – and because patients want to be treated by well-motivated, fairly rewarded employees. The way NHS employers treat employees will in future be part of the core performance measures and linked to the financial resources they receive.' (p. 4)

While there is a significant literature that examines these propositions for private sector US companies (e.g. Huselid⁽³⁶⁾), there are few studies which focus on the UK⁽¹⁶²⁾ and for health care in the UK (e.g. West et al^{(41); (42)}). West et al⁽⁴¹⁾ found in a study of 61 hospitals in England strong associations between HR practices (such as the extent and sophistication of appraisal) and patient mortality. West et al⁽⁴²⁾ demonstrated that this effect held longitudinally, thus giving some evidence for a causal link. Research by McKinsey⁽⁴⁴⁾ suggests that hospital-specific management practices (including a dimension of TM) are strongly related to a hospital's quality of patient care (albeit one measure of 30 day risk-adjusted acute myocardial

infarction mortality rate) and productivity outcomes. In particular, hospitals with clinically qualified managers are associated with better management scores. However, of the seven countries under study, the UK has the lowest proportion of managers with a clinical degree (57.9%), and this suggests that the UK could gain much by encouraging more movement of clinical staff into management. However, according to Hyde et al⁽⁴⁰⁾ a review of the link between HRM and performance found little consistency in results. Storey⁽¹⁶³⁾ writes that much of the research on HR high commitment/performance practices and organisational performance is at best confused and worst conceptually and methodologically deeply flawed. Few sources set out clear propositions linking HR measures, including TM measures, and organisational performance. Moreover, given that effects are unlikely to be instantaneous, there is little discussion of time lags and attribution/causality.

As we saw in Chapter 2, the conceptual foundations of TM have been little explored in the literature. This means that the links between TM and organisational performance are less clear than for broader HRM measures and organisational performance. The most common proposition appears to be:

TM (t0) is positively linked with organisational performance (t1). In other words, positive TM measures lead to future high organisational performance. Organisations that are good at attracting, retaining and promoting staff are likely to be those that perform well. However, it is possible that elements of TM may have the opposite effect: TM (t0) is negatively linked with organisational performance (t1). Organisations with good leadership development programmes may produce staff who leave for promotion at other organisations, or other organisations might recruit from organisations with good reputations for producing leaders. The consequent loss of talent may be associated with poorer organisational performance.

9.4 NHS Staff Survey

We examined material from the latest (2009) NHS Staff Survey⁽¹⁶⁴⁾, which asked almost 290,000 NHS staff for their views on working in the NHS in October 2009, with a response rate of about fifty-five percent. Since January 2010, NHS organisations and providers of NHS services are under a legal duty to take account of the NHS Constitution when delivering services. We focused on the 'Key Findings' (KF) associated with Staff Pledge 2 of the NHS Constitution (to provide all staff with personal development plans, access to appropriate training for their jobs and the support of line

management to succeed) and the 'Additional Themes' of job satisfaction and equality and diversity.

According to the 'Key Findings' report⁽¹⁶⁴⁾ the 2009 survey shows an improvement in the proportion of staff receiving appraisals, up from 64% in the 2008 survey to 69% for 2009. However, less than a third (31%) of all staff felt that their review was 'well structured' in that it improved how they worked, set clear objectives and left them feeling that their work was valued (although this is a marked increase on 24% in 2007 and 27% in 2008). Of those who had an appraisal (or a knowledge and skills development review), three quarters (78%) had agreed clear objectives with their manager (same as in 2008), and 57% felt both that the review had helped them do their job better, (55% in 2008) or had left them feeling valued (54% in 2008). Sixty per cent of staff had agreed a personal development plan as part of their review, up from 55% in 2007 and 52% in 2007. However, only half (50% compared with 49% in 2008) of these staff said that they had received the training, learning or development identified within the plan (a further 29% said it was "too early to say"). Figures on appraisals are poorer for ambulance trusts than in other NHS trusts. Just under half (47%) of ambulance trust staff had an appraisal (although this is substantially up from 41% in 2008). Only 14% felt that the review was well-structured (compared with 11% in 2008) and one third (36%, 35% in 2008) said that they had received the training identified.

Forty per cent of staff across the NHS reported that they had good development opportunities at work (the same as in 2008), with 46% agreeing that there was strong support for training in their area of work (45% in 2008). Opportunities for development were reflected by the majority of staff with 95% (same as in 2008) reporting having had some type of training in the previous 12 months. Attending taught courses was the most common form of training, learning or development (69%, 68% in 2008), and a third of staff (34%) had undertaken self-accessed learning (same as in 2008; markedly higher than the 26% in 2007). Importantly, 79% of those who had accessed training in the past year felt that it had helped them to do their job better or to keep up to date with their job and/or professional requirements (80% in 2008 and 77% in 2007).

Overall 74% of staff are satisfied with their jobs, very similar to the figure for 2008 (73%). The majority of staff were satisfied with the support they received from colleagues (77%, compared with 76% in 2008) and from their immediate manager (61%, compared with 59% in 2008). There continues to be a strong downward trend in the number of staff intending to leave their current jobs. Twenty-eight percent of staff said that they often felt like leaving their trust (compared with 31% in 2008 and 36% in 2007).

Twenty per cent reported that they would probably look for another job in the next year (compared with 21% in 2008 and 24% in 2007), and 14% said that they would leave as soon as they could find another job (15% in 2008 and 18% in 2007).

Overall, 90% of staff across the NHS agree that their trust acts fairly with career progression and promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This is an improvement on the 2007 figure of 87% and the 89% reported last year. However, 7% of staff said that they had experienced some sort of discrimination at work in the previous 12 months. This includes 2% who said that they experienced discrimination on the basis of their ethnic background (12% among black and minority ethnic employees) and 1% each on the basis of gender (2% of men and less than 1% of women), disability and age (2% of staff over the age of 50). Less than 0.5% of staff said that they experienced discrimination on the grounds of sexual orientation or religion. Sixty-five percent of all NHS staff had received training in equality and diversity during their employment at their NHS trust, 40% of whom who had attended such training in the last 12 months (a substantial increase on the 55% and 32% reported in 2008).

9.5 The Five HPTs and the NHS Staff Survey

It can be seen from Table 6 that our FT scored better than average on all the 13 KF. Trusts in the three categories of APT, PCT and MHT scored more positives than negatives. However, for the Ambulance Trust, negative scores outweighed the positive and average scores. However, as noted above, it was difficult to select a clear 'high performing' Ambulance Trust. In general terms, then, for 4 out of our 5 categories, it appears that our HPT had higher than average scores in the dimensions of the Staff Survey that had most relevance for TM.

9.6 HPT Lead TM Interviews

Our three interviews with the Trust leads on TM and leadership reported that TM regarded as important within the Trusts (including hiring external consultants in one case), although the distinction between LD and TM was not fully clear. One Trust saw themselves as a relatively early starter. However, while one informant was aware of the relevant research in the area (e.g. citing Professor Michael West, Aston Business School), it was admitted that the impact of TM on the 'bottom line' of organisational performance was not clear:

"It has to be important because I think to have good leadership within the organisation is essential for the Trust to be successful." (APT 1)

"Relatively early starter. We started before TM was becoming fashionable." (APT 1)

"The Trust is absolutely committed to leadership development." (MHT 1)

Table 6. Staff Survey Key Findings for High Performing Trusts.

	FT	APT	PCT	MHT	AT
Development					
KF11	Positive	Positive	Positive	Negative	Average
KF12	Positive	Positive	Average	Positive	Average
KF13	Positive	Average	Average	Positive	Negative
KF14	Positive	Positive	Positive	Average	Negative
KF15	Positive	Positive	Average	Positive	Negative
KF16	Positive	Positive	Average	Negative	Average
Satisfaction					
KF34	Positive	Positive	Positive	Average	Negative
KF35	Positive	Negative	Average	Average	Negative
KF36	Positive	Positive	Positive	Negative	Average
KF37	Positive	Positive	Negative	Average	Negative
Diversity					
KF38	Positive	Negative	Positive	Positive	Positive
KF39	Positive	Negative	Average	Positive	Negative
KF40	Positive	Negative	Positive	Positive	Negative
N Positive	13	8	6	6	1
N Average	0	1	6	4	4
N Negative	0	4	1	3	8

Key:

KF11. % feeling there are good opportunities to develop their potential at work

KF12. % receiving job-relevant training, learning or development in last 12 months

KF13. % appraised in last 12 months

KF14. % having well structured appraisals in last 12 months

KF15. % appraised with personal development plans in last 12 months

KF16. Support from immediate managers

KF34. Staff job satisfaction

KF35. Staff intention to leave jobs

KF36. Staff recommendation of the trust as a place to work or receive treatment

KF37. Staff motivation at work

KF38. % having equality and diversity training in last 12 months

KF39. % believing trust provides equal opportunities for career progression or promotion

KF40. % experiencing discrimination at work in last 12 months

To preserve anonymity, 'positive' includes the two categories of better than average and the best 20% of trusts, while 'negative' includes the two categories of worse than average and the worst 20% of trusts.

"Leadership development is very important within the trust and is seen as absolute priority, right from CE and Board level." (MHT 1)

"The previous CE was very keen to support leadership and management development." (MHT 1)

"We know that we can't achieve everything we want to in our business plan going forward without some very skilled people who we can rely on in a distributed workforce." (AT 1)

"We identify talent using 360 degree review; we ask senior managers to identify two key people from their directorates." (MHT 1)

"Importance of valuing staff; organisational development, but OD needs to sit outside HR." (MHT 1)

"The honest answer is It's very difficult.... to link interventions for leadership to the success of the organisation." (APT 1)

There were some different issues about the relationships between organisational and hierarchical, system SHA requirements:

"Some returns to SHA were not helpful- hitting the target rather than doing things in developmental way." (APT 1)

"FT have more autonomy, and can make their own decisions- whereas PCT were given the mandate to roll it out quickly through the SHA." (MHT 1)

"It is fair to say that as a very late entrant into all this as an ambulance trust, we have not had the tension [between SHA and organisation plans] and we've felt very supported by the SHA." (AT 1)

The appraisal process was seen as particularly important in the provider trust:

"Everyone is expected to have an annual appraisal and from that everyone is expected to have a PDP as well. And a lot of energy goes into that." (APT 1)

"Programmes individualised, tailored to people's PDP." (APT 1)

All three organisations appeared to take some ownership of TM, and had an exclusive rather than an inclusive approach to TM:

"I see TM in terms of managing the whole of the workforce rather than the higher levels that the SHA seems to be concentrating on." (APT 1)

"We ran internal and external courses, in addition to SHA courses." (APT 1)

"Range of programmes, including commissioned." (MHT 1)

"What we are trying to do is ensure that we have opportunities at every level and so that it filters down. I think one of the key challenges is ensuring that we get to all of those levels." (MHT 1)

"... [problem of ensuring fair access] make sure that we are getting the right people on the courses. [Need to ensure that not] the cart before the horse." (MHT 1)

"LDP was particularly targeted at the middle grade clinical managers." (AT 1)

The Ambulance Trust presented a possible paradox in that it has always contained clinicians as managers, it was not ahead of the game in TM:

"[Strong focus on developing clinicians as managers] We generally feel that we have not sufficiently developed our clinical leaders to the extent where they would be able to switch into a more general management role." (AT 1)

"We have one or two very hard performance targets and we feel that by focusing on those with a general manager who is not clinically focused, we are beginning to lose sight of the clinical quality in clinical matters and we think that by developing the clinical staff into leaders this will help to future proof us post Mid Staffordshire." (AT 1)

All Trusts were aware that they were at various points on their TM journey, and the Ambulance Trust was well aware of its starting point on that journey:

"The programmes are there, but actually in terms of really pro actively spotting talent and doing that in a formal way, I think that's only just sort of kicking off]." (MHT 1)

"I think traditionally in ambulance services there hasn't been a great deal of management and leadership development." (AT 1)

"[We are a] a very late entrant into all this ... Ambulance service is a very uni-professional service, and it's also not being seen as particularly attractive as part as a more general management plan. That's changing and we e beginning to attract people into what would be sort of assistant director roles as part of their career development, and that's been quite a change." (AT 1)

"Having access into the SHA programmes has been new for the ambulance service so I think that our issues are probably different from the acute trusts or the PCTs who have had access to this for a lot longer than we have." (AT 1)

"[Journey?] I think we are about 60% there." (AT 1)

9.7 HPT Staff Interviews

Much of the content of the staff interviews broadly followed our cohort interviews (Chapter 8). There appeared to be few clear differences between the 'high performing' groups and the general cohort group in terms of the support of the organisation and line mangers, experiencing barriers, and the level of secondments. Our informants broadly confirmed our TM informants that development was seen as important in the organisation. In one organisation, a TM had been set up as a kind of ALS from the 'bottom up' as an objective from a person's appraisal. Some believed that it had a positive impact on organisational performance. Finally, some respondents at the PT spoke of a sense of loyalty to the organisation, although this was not clearly reflected in the Staff Survey finding on intentions to leave:

"PD is very important and I think it is something that X actually takes very seriously; X is very committed to developing people." (APT 3)

"It is very important for the trust for the staff to be developed; I think the staff feel invested in." (APT 4)

"The Trust has a strong commitment to leadership and management. Our former CE was very passionate about OD." (MHT 2)

"This Trust does invest heavily in leadership." (MHT 5)

"Think development is an important element in organisational success." (MHT 3)

"The organisation is extremely supportive and ... keen to say... go and do the programme and ... basically don't worry about the day job too much." (MHT 6)

"[Impact of development on trust?] I think it's absolutely crucial. There's a greater awareness of more people about leadership development ... that I don't think systematically was there ten years ago." (MHT 6)

"[Impact of development on trust?] ... 'definitely'; benefits are huge." (APT 5)

"PD 'absolutely vital' to success of Trust." (AT 3)

"ADP sort of mandatory; did not get a choice actually." (APT 1)

"PD is absolutely key if you want to continue to evolve your business... it all rests on staff development at the end of the day." (AT 6)

"[Previously worked in LA] AT more encouraging than LA; see the benefits then they will do their utmost to accommodate; PD 'imperative' for organisational success." (AT 2)

"PD is important to the organisation. I think education underpins all the work that we do. Historically we have always had a good reputation in terms of opportunity for CPD and I am sure that is one of the reasons why we attract good quality people and why we retain good quality people. Many people here have been here since

they qualified and then they retire here, it's the sort of Trust where you come and you have your working life here." (APT 2)

"I am on the 'radar' as an aspiring director, but I am loyal to X so would want to stay and I think that if you ever get the chance to work here then you would understand why; if I left would want to come back as a director." (APT 2)

Respondents from the AT considered that they were not as advanced on their TM journey compared to other NHS organisations:

"The ambulance service is the last real bastion of development, particularly the clinical development." (AT 1)

"Have identified people onto ADP; may move on but positive- by having someone who is high quality who has been trained within the ambulance service, I think it does a lot for the reputation of the service, but also need to bring in people from outside into what has traditionally been a bit of a monolithic organisation. A little bit of a revolving door." (AT 1)

"As almost a generation [then HA, rest of NHS] behind in terms of PD of staff. Quite insular. People historically promoted through the ranks who are very good clinicians but he not got an ounce of management awareness or capability." (AT 3)

"Were quite a way behind in development, but well on the road now. Exposure to other parts of the NHS a big eye opener; exposure to different parts of the NHS for new managers coming in should almost be compulsory." (AT 3)

The Trusts also appeared to take clinical leadership seriously.

"I don't think there was an emphasis in my early years on the value of clinical leadership; now investing a lot of time and money in clinical leadership; now fully encouraged; professional development is 'very important' in trust; led by the top; clear emphasis on liberating talent, especially within the clinical bands ..." (MHT 4 - nurse)

"... current TM is the Darzi stuff; something I am very passionate about as we never got any leadership training at medical school, or as a junior doctor or registrar; gives a sort of them and us mentality and I think you have to have leadership and management skills taught at the very beginning to overcome that suspicion and move the organisation forward; more clinicians in management is

important; value of clinical background- absolutely 100% believe that; crucial because you have a knowledge of the internal workings of the hospital; clinical knowledge makes a holistic sort of thing." (APT 3 - doctor)

"I actively practice. My car is in the car park with a blue light stuck on the roof. ... I do not want to focus completely on management; many people have let their paramedic qualifications slip and actually they misread the signs because the clinician is king at the moment. A peculiarity of the health service. It is amazing how many NHS managers had a clinical background but almost seem to abdicate it or become divorced from it in order to make themselves more credible as a manager. There was a culture where you were not credible as a clinician in a management position but now it is the other way around." (AT 4 - paramedic)

One respondent in particular considered that TM in their organisation would remain important despite pressures on budgets:

"In the past when there has been financial constraints on Trusts, some of the first things to go would be education, but I do not think that is the case now and I think that directors and other senior staff within organisations are realising that we need to maintain education, in fact we probably need to even boost it as there will be different requirements within the new organisations." (APT 2)

Most of our interviewees considered that the majority of courses that they had been on were positively evaluated and had a positive impact on their career and the organisation:

"[SHA Course] 'outstanding', 'most amazing course'; especially important for clinicians who do not 'live, breathe and eat' management for years." (APT 3 - doctor)

"... coaching and mentoring are hugely important." (APT 3)

"Fantastic impact of programmes on career. I would like to think it's been effective for the organisation. But opportunities have probably benefited me and my career more than the organisation." (APT 1)

"[2 pages of A4 of management training and development] ... five day residential management development module in 1990s was 'brilliant experience'; took me to a different level of management." (APT 5)

[Masters] *"One of the best decisions I ever made- new post."* (APT 5)

"... two days- so intense it was almost overwhelming." (APT 5)

The stress put on appraisals and the links with PDP by our TM informants was broadly shared by the interviewees, which appears to confirm the Staff Survey findings for the PT, but not clearly for the MHT or AT. Moreover, it was felt that the appraisal process had some shortcomings, particularly being seen as a 'tick box' exercise:

"... identify development needs through PDP." (APT 2)

"We have appraisals, but I don't like them to be honest with you; almost like a tick box exercise." (APT 4)

"I appraise 7 people, and just noticed 4 had slipped to 18 months or 2 years- and I was absolutely horrified." (APT 5)

"...forms could be more joined up and user friendly." (AT 2)

"Programme came up as part of PDP." (MHT 2)

"Appraisal- quarterly reviews and yearly action plan. MSc was borne out of action plan." (AT 4)

"Had first appraisal this year since joining in 2004. [Q-problematic?] I did not think so until I had the one this year. Had informal conversations, but formal conversation was very, very useful." (AT 3)

"... external consultancy with director's appraisal; whole board appraisal; 360 degree, includes targets; appraisals have traditionally been very low numbers and not done terribly well in the ambulance service, so for this year I've got the director's appraisal pack and the board appraisal. Target of 100% for back office staff which was achieved; and going for 100% for clinical and road staff-major turnaround; staff survey is awful in the ambulance service. One thing that comes out loud and clear is that if no one has an appraisal, then you have not got the ability to do a proper training

needs analysis from it; need to do something about staff survey." (AT 1)

One major important difference, which corresponds with our TM informants, is that our HPT appeared to take a more exclusive approach to TM, with CPD cascades further down the organisation; and not confined to ACE and AD:

"I strongly believe that TM should not stop at people who are at AD level. My belief is that we need to start going into schools and colleges and developing NHS leaders of the future from the age of 16 onwards." (APT 2)

"I think that they are very keen on you doing some sort of training in the NHS, and it is almost a case of 'do some training, we don't care what'." (APT 4)

"I think that leadership development is often focused at the higher band of staff and tends to forget the up and coming leaders and people at much lower bands. What we have tried to do in through our programmes is try and think about not just the senior leads, but about everyone else. Looking at the whole not just a bit of it. Need to embed it across the organisation [vs cascade; trickle down]." (MHT 1)

"OD programme cascaded through department." (AT 3)

It is possible that individuals in the HPT may be *less* ambitious than the cohort groups in general. However, this finding was not clearly supported by the Staff Survey returns (above, especially KF 34 and 35). If so, this may mean that talented individuals stay with the organisation rather than seeking promotion elsewhere:

"Emphatic NO to CE. I looked at it and decided it was not for me. I don't think I would make a very good CE. I think I'm better at leading a service and then being second in command." (APT 1)

"I do not see myself at Director level- heavy workload at moment and it can only get worse." (APT 4)

"Not everyone can be CE or Director." (APT 5)

"Sideways move was a deliberate step. People said it was a downward step, but I absolutely love it and it was absolutely the right thing to do." (MHT 1)

"Not looking beyond director level; would not be interested in a CE job." (AT 1)

"Not sure I would really want to be a CE (AT 2)

"I don't want particularly to aspire to be a director [but ADP was mandatory]." (AT 3)

Only one respondent was really sceptical and critical of the TM agenda in their organisation, but – as in the cohort interviews- these views are held by a significant minority of people, and corresponds to issues such as bullying in the Staff Survey, and in reports⁽¹⁶⁵⁾:

"A genuine sense that my director did not want me to develop; our directors are very defensive and tend to stick together. The organisation is probably the worst organisation I have worked in for that type of behaviour... very defensive closed rank kind of like Freemasonic connotations... I feel bullied, intimidated and undervalued. There were false ceilings and hoops that you had to jump through which were not merit based [Promotions are] based on personalities and favours rather than merit. Some people have managed to get on despite not necessarily being the best people." (AT 5)

9.8 Conclusions

The literature is far from clear on the links between TM and organisational performance. We aimed to explore these links in two main ways. First, evidence from the NHS Staff Survey suggests some association between high organisational performance and high performance on the KF that are broadly relevant to TM for our five selected organisations. Second, interviews with a TM key informant and staff at three Trusts suggest five tentative findings. The first is that a TM policy must be a 'living, breathing' rather than a 'paper' policy. Staff must be aware of, and broadly 'signed up' to the policy. Most of our interviewees recognised the importance of personal development in their Trust, and some saw the link between it and organisational performance. The TM group in one Trust illustrates a willingness to develop a 'bottom up', more inclusive approach rather than

simply complain of a 'top down', exclusive approach. The second is the stress placed on exclusive rather than inclusive approaches (cf Ford et al 2010). All three organisations appeared to take some ownership of TM, and focused on the whole workforce rather than simply top leaders. The third points to the importance of clinical leadership. The fourth finding suggests the importance of the appraisal process and PDP as the bedrock for TM. The final (very) tentative finding suggests that organisations with more *less* ambitious individuals may mean that talented individuals stay with the organisation rather than seeking promotion elsewhere.

10 Conclusions

10.1 Introduction

There has been much recent debate on NHS managers. There has been much (often uninformed) public criticism of NHS managers on quantitative (too many, too highly paid) and qualitative (inferior to the private sector) grounds. Managers are often contrasted with clinicians in terms of the “Animal Farm” mantra of “grey suit, bad; white coat, good”. Within the NHS, there has been a focus on management and leadership. Issues include the problems of recruiting CE and their short average tenures⁽²⁷⁾; a perceived or real toxicity in the wider system inhabited by chief executives, describing the environment as “brutal”, “arbitrary”, “prone to favouritism” and intolerant of risk-taking that isn’t successful^{(156); (166)}; an insular club that exhibits a suspicion of outsiders, and wields patronage⁽¹⁶⁶⁾ and leadership that does not reflect the community or workforce^{(35); (30)}.

The NHS Next Stage Review report, *High-quality care for all*⁽¹⁰⁶⁾ states that leadership has been a neglected component of the reforms until relatively recently. However, as the NHS Confederation notes⁽¹⁶⁶⁾, investment in leadership development and significant changes to delivery were a feature of the 2000 NHS Plan (which mandated the creation of the Leadership Centre) and the creation of the NHS Institute for Innovation and Improvement. In fact, this appears to be the fourth reorganisation of leadership development in ten years, which suggests that diagnosing the problem of NHS leadership is less straightforward than has been assumed⁽¹⁶⁶⁾:

“We would argue that debates about the need to improve management and leadership in the NHS have been going on at least since the Griffiths Report on NHS management in 1983”. (p. 2)

There has perhaps been too much focus on “narrow” leadership (for example, one of the most visible parts of TM is the TLP)⁽¹⁶⁶⁾:

“Concentrating on the top jobs misses the fact that a shortage of talent at chief executive level may be the result of similar problems further down the pipeline. Much of the criticism of NHS management is directed at the quality of middle at the quality of middle management rather than chief executives”. (p.2)

10.2 *Review of Main Findings*

We noted in Chapter 1 that there is little consensus about the definition, scope and effectiveness of TM. Moreover, much of the work on TM focuses on the US and the private sector, and there is very limited work on the UK in general and the public sector and the NHS in particular (but see Ford et al⁽⁷⁾). As reported in Chapter 1, the key findings of a CIPD report⁽⁴⁾ conclude that about half of the UK organisations surveyed undertake talent management activities, although only 20% report having a formal definition for it, with TM is more common in private sector and larger organisations. In-house development programmes, coaching and succession planning are the most common activities, with the most effective practices are in-house development programmes; internal secondments; and coaching. Succession planning, external secondments and action learning are considered to be the least effective. Organisations tend to have an 'exclusive' approach, with a focus on their 'high potential' employees, although less than a third of respondents agree that activities should be focused on high-flyers or high-potential employees, with two-thirds agreeing that using the term 'talent' can be demotivating for employees not selected to take part. This more inclusive perspective on talent management is further supported by about half of respondents who also agree that special attention needs to be paid to identifying and managing talent within certain groups of workers such as women, ethnic minorities and older workers. In 2004 the NHS adopted a new approach to identifying and developing managers with the establishment of a national talent management team⁽²⁴⁾. However, Blass⁽²²⁾ argues that every organisation has a talent management system whether it recognises it or not', and so we examined long-standing 'mt' initiatives before 'TM'.

A literature review (Chapter 2) explored the TM literature. It was found that definitions and scope of TM were often unclear and contested, and there is little robust evidence that TM contributes to organisational performance. There is little robust evidence on the most effective types or elements of TM, nor whether it is more effective in certain contexts (such as particular types of industry). In particular, there are major differences between 'inclusive' and 'exclusive' approaches to TM, whether it should be focused on the whole workforce or simply the 'A players'. In short, we are far from clear as to whether TM 'works'. Most of the literature focuses on the USA and the private sector, and there is relatively little material on the UK and the public sector and particularly the NHS, but Ford et al⁽⁷⁾ provide some insight into TM in a regional setting in the NHS. Their view is that the NHS in this area is focusing on a 'hard-HRM' approach which treats managers and individuals as resources, albeit human resources, to be planned and scheduled.

Chapter 3 reviewed mt and TM in the NHS from 1948 to 2011. While there was much 'mt' in the NHS (for example, the MTS dating from 1956), much of it tended to be rather ad hoc, informal, variable and not joined-up. The new TM approach after 2004 aimed to improve this situation, with three main programmes (MTS, Gateway, Breaking Through) run by the NHS Institute, and courses for Aspiring Chief Executives, Aspiring Directors, and Clinical Leaders. Leadership was stressed by the Darzi Report⁽¹⁰⁶⁾ and the setting up of the Nation Leadership Council in 2009, with five workstreams, with the first four concerned with managers: Top Leaders; Emerging Leaders; Inclusion; Clinical Leadership and Board Development. The central document in the new approach is 'Inspiring Leaders'⁽¹⁰⁸⁾ which required each SHA to have a completed T&LP by July 2009 (Chapter 6). However, almost as soon as TM was seen as an organizational imperative, TM entered a cold climate with a 'double whammy' of the need to make management savings and organizational change, including the abolition of PCTs, SHAs and the NHS Institute.

Chapter 4 explored views of TM through two sets of Focus Groups. Thirteen people attended two Focus Groups in late 2009. The participants were first asked to draw out their career journeys as a 'map'. Eight people had begun their working lives in the NHS, including four in clinical roles. Although eleven individuals had taken some form of additional study that was associated with their career, there was some dismay at the current attention given to the requirement for academic qualifications. Many individuals pointed to supportive managers as enablers to their career, and only one noted a specific organisation based block to their career in the form of an 'unmistakeable glass ceiling'. Two further focus groups of eleven people in total were held in late November and early December 2010. In contrast to the first set of Focus Groups, more participants were familiar with the term TM, and generally considered that the new TM system was an improvement. However, some had concerns that and thoughts that TM may only apply at certain senior levels, and the system is necessarily variable as it still relies on individual 'talent spotting'. A number of participants questioned the extent to which the NHS was one system like a private company.

Chapter 5 compares the national DH guidance for NHS Talent and Leadership plans⁽¹⁰⁸⁾ with the SHA Talent and Leadership plans. Although many of the SHA Plans broadly followed the 'Inspiring Leaders' framework, they came in various shapes and sizes, with differing contents, some of the 'givens' were not fully clear, and it was difficult to collate the data into a clear template. The 'Diagnosis' section reports the SHA Dashboard, which gives details of the supply and demand of CE and Directors, the level of inclusion (gender, BME, clinicians), talent spotting, and the Staff Survey. SHAs are 'spoilt for choice' when they have at least three appointable

candidates for each vacancy. Some SHAs claim to be SFC for most or all posts, while others indicate gaps. However, these figures may underestimate supply as we argue that SFC requires $N+2$ rather than $N*3$ candidates (where N is the number of vacant posts), but overestimate supply in that the talent pipeline may not be sufficiently validated. Most SHAs report that their leadership is not inclusive, particularly in terms of BME leaders. Most SHAs had much actual and planned activity to close gaps, and varying budgets. In addition to Aspiring CE and Aspiring Director programmes, most were involved in activity to build clinical leadership and diverse leadership. Data from the available SHA Assurance Reports show that scores for the workforce arena was broadly low, with the lowest scores for the “everyone counts” (diversity) indicator.

Chapter 6 focuses on about twenty central and SHA interviews. Although it was generally agreed that the TM system was a great improvement of mt, there were concerns issues of variability and sustainability. It was not clear whether it was possible to have the sort of TM that leading private sector companies have, nor whether there was a ‘system’ in the NHS, or a collection of organisations, which had implications for whether the ‘system’ was competitive or collaborative. Context was regarded as important in two main ways. The first relates to SHA flexibility to adapt the central guidance, and the second relates to local circumstances. The three main central programmes of MTS, Gateway and Breaking Through were broadly positively regarded. There were some concerns about TM at the national level, particularly that schemes are not always ‘joined up’ and over the ‘Top Leaders Programme’. There were concerns about patronage, the engagement of FTs, the identification of talent, particularly the lack of a common system or database, and that NHS leadership was not representative of workforces or communities. The future of TM was unclear. Some saw a positive future for TM. Others foresaw a ‘cold climate’. It was felt that it was ‘early days’ on the journey to TM, and that it was too early to evaluate its impact.

Chapter 7 presents the results of a survey of NHS managers. This shows that they constitute a highly qualified workforce, which continues to undertake professional management programmes/activities. About 95% of those who had been on programmes/activities stated that they were of value. The main facilitators that enabled staff to pursue development opportunities were in order of incidence self-motivation, support from line manager and senior managers and PDPs arising from appraisals. Of the 90 people who had not undertaken programmes/activities, 81% reported that ‘constraint’ factors prevented them taking it up, with the main reasons being time and funding, with the remaining 19% broadly represented ‘choice’ factors such as having previous development experience or being too close to retirement. Some 37% stated that they had experienced some

barriers or obstacles in obtaining chosen training or once on the programme or activity. The main barriers to accessing development were seen as lack of organisational support and lack of funding. Once on the course, the main barrier was seen as lack of dedicated study time, leading to people trying to juggle work, study and home commitments. It appears that a higher proportion of female and BME staff tended to report barriers and had not undertaken programmes/activities due to constraint rather than choice factors, although the differences were not substantial. Just over a third were aware of the current TM initiative in the NHS, with small differences in terms of gender and ethnicity, but larger differences for age, cohort, seniority, and organisational type. Of those who were aware of TM, a significant proportion expressed concerns either of principle or detailed implementation.

Chapter 8 provided the 'depth' element to complement the 'breadth' of the survey with cohort interviews. Many said that they had not faced any significant barriers, although a few BME respondents did point to significant barriers. One of the few general barriers or obstacles mentioned were the juggling of work, study and life balance. Some respondents had very clear ambitions, while others expressed a mix of less ambition and more realism. Most respondents had concerns about the precarious nature and short average tenure of CE. While a few saw this in terms of individual or agency reasons, more pointed to structural or system factors, while the largest group pointed to a mix of both factors. Our respondents had attended a wide variety of development activities, which ranged widely in provider (in house versus external; bespoke versus generic), length and level. Experience of courses was mixed, and some felt that courses were an 'entry ticket', and were more for CV purposes rather than any inherent benefit per se, which can devalue the experiential knowledge of other managers. Some pointed to the difference between courses for 'development' and for career advancement. While many people had some time off to attend courses, most respondents pointed to the problems of finding sufficient study time. It is difficult to reach any consensus on which are the 'best' courses, because of the wide variety of courses and low numbers of respondents, and because 'one size may not fit all'. Most stressed the importance of coaching and mentoring, action learning sets, and secondments. Networking was regarded as very important, although there did appear to be some negative connotations of exclusion. The appraisal process was broadly viewed in negative terms in both quantitative and qualitative senses. It was generally felt that MT systems were good in principle, an improvement on 'mt' and were needed in the NHS, but knowledge of it tended to be fairly limited. Many felt that the NHS had made some progress on its TM journey, but it was still early days, and that the impact of TM was very variable between and within SHAs. There were varied views about individual elements on the TM initiative, particularly the TLP due to reasons of selection and transparency, and the effect on the morale of those not chosen. There were

concerns that the NHS was too slow on its inclusion agenda. There were a few concerns about the impact of TM, and how the elements fitted together. There were some concerns about the future of TM, given that previous initiatives have not been sustained, and the competition for resources in a more austere funding era.

Chapter 9 examined TM in High Performing Trusts, and explored the link between TM and organisational performance. However, the conceptual foundations of TM have been little explored in the literature (Chapter 2) which means that the links between TM and organisational performance are less clear than for broader HRM measures and organisational performance. We selected five high performing Trusts representing different organisational forms (Foundation Trust; Acute Provider Trust; Mental Health Trust; Primary Care Trust; and Ambulance Trust), and examine these links in two broad ways. First, we examine evidence from the NHS Staff Survey. Second, we conducted interviews similar to the Cohort interviews (Chapter 8) in high performing trusts. This should give some information on whether TM in high performing trusts is different to the national picture. Staff Survey data shows that our FT scored better than average on all the 13 KF. Trusts in the three categories of provider APT, PCT and Mental Health Trust scored more positives than negatives. However, for the Ambulance Trust, negative scores outweighed the positive and average scores. However, as noted above, it was difficult to select a clear 'high performing' Ambulance Trust. In general terms, then, for 4 out of our 5 categories, it appears that our HPT had higher than average scores in the dimensions of the Staff Survey that had most relevance for TM. We carried out interviews in three HPT that had a similar interview schedule to our Cohort Interviews (Chapter 8) and spoke to a key informant on TM. According to the key informants, TM was regarded as important within the Trusts. The appraisal process, and the links between PDP and development, was seen as particularly important in the provider trust. All three organisations appeared to take some ownership of TM, and had an exclusive rather than an inclusive approach to TM. The staff interviews broadly confirmed the narrative of the key informants. There appeared to be few clear differences between the 'high performing' groups and the general cohort group in terms of the support of the organisation and line managers, experiencing barriers, and the level of secondments. However, possible differences included development being seen as important in the organisation, with clinical leadership and PDPs arising from the appraisal process being taken seriously, and there appeared to be a more inclusive approach to TM. One final possible difference was that individuals in the HPT may be *less* ambitious than the cohort groups in general, meaning that talented individuals stay with the organisation rather than seeking promotion elsewhere.

10.3 *Main Themes*

A number of main themes can be 'triangulated' from the variety of different data and Chapters. Table 7 gives an impression of the strength of the theme from the different sources.

A number of themes will be explored in more detail. First, there was considerable discussion about whether the NHS should have a TM system and, if so, what form it should take. It was broadly agreed that the NHS should have a TM system. It was broadly agreed that the TM system was 'long overdue' and was an improvement on the more informal, variable and ad hoc system that it replaced. However, many respondents considered that the previous system cast a long shadow in that the new system could perpetuate, and even legitimate, the 'old boys network'. Similarly, while one of the main aims of the new system is to increase diverse leadership in the

Table 7. Triangulation of Main findings

	Focus Groups	Central Interviews	Cohort Interviews	Survey	High Performing Trusts
TM as improvement	+	++	++	+	+
Uncertainty about system	++	++	++	+	+
Enablers	Financial support LM Senior Managers (SM)	NA	Financial support LM SM	Financial support LM SM	Financial support LM SM
Importance of clinical leadership	+	++	+	+	++
Barriers	Few	NA	Few	Moderate	Few
Concerns about patronage	+	++	++	+	+
Concerns about (identity) diversity	+	++	++	+	
Concerns over credentialism	+	+	++	+	
Concerns that TM exclusive	+	++	++	+	++

Key:

++ = strong support; + = some support

NHS, some considered that it had the potential to be ageist, sexist and racist.

Some claimed that the private sector has 'led the way' on TM, and several examples on organisations in the private sector were given. It was considered by some that TM schemes tended to be universalistic, and that private sector schemes can largely be adopted by the NHS. Others held a more contingent view, arguing that private sector schemes assume a more directive approach to staff, whose careers can be plotted like moves in a game of chess. Some suggested that private sector schemes may be more exclusive and elitist, focusing on the 'A players', while the NHS should have a more inclusive scheme. Similarly, it was argued that the public sector needs to take more of a lead on equality and diversity issues, which might be less of an issue for some private sector companies. Finally, opinion was divided (particularly in the national interviews) as to whether the NHS was and should be a single co-operative system or a collection of competing organisations. This leads to the fundamental issue of whether the system or the employer 'owns' the talent, and whether talent can be 'shared' or 'poached'.

Turning from the system architecture towards more specific details, most respondents stated that the system needs to become more open and transparent, and some wished to see 'open access' and self-nomination to courses and activities. However, as it is likely that courses and activities represent scarce resources for which demand will exceed supply, this might simply raise expectations and increase disappointment for those not selected. Others recognised the necessity for selection, but argued for clearer and more consistent criteria of selection, with full and 'honest' feedback for those not selected. The importance of clinical leadership was broadly recognised. The problem of the short tenure of CE was recognised, with most respondents focusing on 'system factors' that were associated with a high turnover of CE and persuaded many talented staff that they did not wish to become CE. Many respondents pointed to the lack of diverse leadership in the system. While most of these focused on 'identity diversity' (e.g. race, gender), a few considered that 'cognitive diversity' was also important. In other words, conformity was valued leading to few 'mavericks' willing to put their heads 'above the parapet'. There were some concerns over 'credentialism' in that 'paper qualifications' were seen as 'entry tickets' to particular levels, with the devaluing of experiential learning.

The main facilitators that enabled staff to pursue development opportunities were self-motivation, support from line manager and senior managers and PDPs arising from appraisals. It is clear that all these are highly variable. It

is unlikely that the system has much control over levels of self motivation. However, support from line and senior managers varied from great encouragement to indifference to hostility. While the 'talent spotting' capacity and capabilities of managers are always likely to vary, we came across few examples of the stress implied by the 20% of CE time suggested by 'Inspiring Leaders'⁽¹⁰⁸⁾ or the great emphasis placed on executive succession as suggested in some private sector accounts. Similarly, the quantity and quality of appraisals varied greatly. At worst, they were neglected or regarded as 'tick box' exercises. Opinion was divided as to whether formal or informal appraisals were better, but there was general agreement that more 'honest conversations' were required.

The findings on barriers from the different data sources did not seem to be consistent. There appeared to be relatively little discussion of barriers in the qualitative interviews, but over a third reported barriers in the quantitative survey. However, there was some consistency in the nature of the barriers. The main barriers to accessing development were seen as lack of organisational support and lack of funding. Once on the course, the main barrier was seen as lack of dedicated study time, leading to people trying to juggle work, study and home commitments. There was also some consistency in that more female and BME staff tended to report barriers, which were perceived as very severe in a few cases.

The courses that were attended were broadly positively regarded in terms of content, but there was less consensus on the benefits for the individual and the organisation. This partly depends on whether the main outcomes are expected in terms of individual personal development or career advancement, or organisational effectiveness. While it is difficult to reach clear conclusions about the benefits of courses, there was much less evidence on the costs of courses. Courses came in all shapes and sizes, and varied in terms of length, location, provider, content, and aims. There appears to be little evidence on whether the current mix of courses is broadly correct. For example, are some courses better value than others? Should more resources be directed to (say) 'Breaking Through' as opposed to clinical leadership? Should the NHS agree on a restricted set menu or continue to support a wide choice of a la carte courses?

Finally, given the financial climate, reorganisation, and threats of redundancy for some, there were great concerns over the future of managerial careers in the NHS. Some concluded that they had no future in the NHS. Others considered that TM had no future in the NHS. Some stated that investment in TM should in theory increase in times of upheaval, but the broad view was that it was easier to make cuts in leadership

development than in front line services, and that TM would decline only to rise again at some future date.

10.4 *Revisiting Aims / objectives*

In this section, we re-visit our main (1-3) and secondary (4-5) aims of the study.

1. To examine the mt/TM approaches that assisted the career trajectories of four cohorts

We have shown that while there were few new individual elements in MT which were not in tm, but TM was felt to be more systemic. However, knowledge of TM was often fairly limited. Although most respondents with knowledge felt it was an improvement, some remained to be convinced that it would be a fair and transparent system that eliminated 'patronage' and the 'old boys network'. Age and cohort did not appear to be associated with major differences in terms of individual elements. However, it was felt by some that there was now more stress on 'paper qualifications' or 'credentialism' that perhaps devalued experiential learning.

2. To examine the facilitators and barriers to talented individuals achieving their potential

The main facilitators that enabled staff to pursue development opportunities were self-motivation, support from line manager and senior managers and PDPs arising from appraisals. While there appeared to be relatively little discussion of barriers in the qualitative interviews, over a third reported barriers in the quantitative survey. The main barriers to accessing development were seen as lack of organisational support and lack of funding. Once on the course, the main barrier was seen as lack of dedicated study time, leading to people trying to juggle work, study and home commitments. While there were few perceived differences between groups in facilitators, more female and BME staff tended to report barriers.

3. To evaluate the impact of different Talent Management (TM) and earlier 'managing talent' (mt) schemes on individuals

It was broadly felt that much of mt tended to be rather ad hoc, informal, variable and not joined-up, and that MT was a significant improvement. Development courses and activities were generally felt to be beneficial to individuals, but the impact on organisations was less clear. It was not possible to identify a single 'best' scheme as 'one size did not fit all' in that various schemes were favoured by different people for different reasons.

4. To explore how values, motivations and beliefs link with managerial careers

A wide variety of values, motivations and beliefs were given by respondents, with a major emphasis being placed on 'making a difference'. However, there was no obvious link with individual career trajectories, apart from the observation that not all staff wished to become Directors or CEs.

5. To examine how TM links with organisational success

Links between TM and organisational success are far from clear, but possible differences included development being seen as important in the organisation, with clinical leadership and PDPs arising from the appraisal process being taken seriously, and there appeared to be a more inclusive approach to TM. One final very tentative difference was that individuals in the HPT may be *less* ambitious than the cohort groups in general, meaning that talented individuals stay with the organisation rather than seeking promotion elsewhere.

10.5 *Implications for NHS Managers*

Given, at the time of writing, the great uncertainties over the financial and organisational landscape in the NHS, it is difficult to point to firm implications for NHS managers. The research was conducted with SHAs being major players in TM, and the future of TM is unclear. Recent workforce documents^{(125); (126)} do not discuss TM, and when education and training or CPD are discussed, the focus appears to be on clinicians, with very little mention of managers. However, the direction of travel appears to be towards employers as 'engines'⁽¹⁶⁷⁾ in a more decentralised and localist NHS.

If the focus seems to be on individual employers rather than the 'system' (see above), then it is likely that variability will increase^{(123); (124); (126)} with some organisations placing more stress on TM and LD than others. This will make a consistent TM scheme problematic as the definition and measurement of 'talent' may vary between employers. Lessons from previous reorganisations suggest the need to monitor carefully the loss of talent, 'organisational memory' and the level of diverse leadership.

Assuming that the TM initiative continues in some form, it is clear that greater efforts are required to ensure that staff are aware of it, and to cascade initiatives from higher levels to the workforce as a whole. A significant minority need to be persuaded that the TM initiative is an open and transparent system rather than old patronage in new bottles. In particular, the evidence suggests that female and BME may feel disadvantaged in terms of barriers. Improving the quantity and quality of

appraisals appears to be a basic foundation for any TM system. Clinical leadership appears to be linked with organisational performance. Some consideration should be given to the package of TM activities that are consumed, and to maximising the effects of such activities, as it is possible that the time conflicts between work, study and home may not allow participants to draw the maximum values from courses. Finally, it is possible that TM may need to take a rather different form in times of uncertainty, reorganisation and austerity than in times of expansion. Given these caveats about the uncertain direction of travel for TM, our recommendations are:

1. Identify who will take responsibility for TM in the future.

It appears that employers, and Provider Skills Networks (or Local NHS Education and Training Boards) will be responsible for workforce (including education and training, CPD) issues, although Health Education England and the Centre for Workforce Intelligence (CfWI) will also play some role. It is important that the TM initiatives associated with the SHAs, the NHS Institute and the NLC are built on rather than forgotten.⁽¹²³⁾ It is also likely that huge variation in the support for CPD within and between organisations and across the NHS^{(123); (124); (125)} may continue, unless there is some mechanism to stress its importance.

2. Take a more inclusive approach to TM.

Although the evidence base for the effectiveness of TM is limited, most of the documents discussing TM in the NHS⁽⁷⁾ as well as the majority of our interviewees, stress the importance of an inclusive (rather than an exclusive) approach to TM. This fits with the ethos of the NHS Constitution and equality and diversity initiatives that stress an NHS of all the talents in which everyone counts.

3. Awareness of the TM system needs to be increased throughout staff in the NHS.

Our survey and interviews suggested that a significant proportion of managers in the NHS were unaware of TM. This included some who had been on AD and other courses that are part of TM. However, better publicity and 'marketing' may be necessary in order to maximise the effectiveness (managers with talent need to be aware of relevant opportunities) and fairness (greater awareness and transparency might reduce feeling that development is reserved for a favoured group) of TM.

4. Quantitative and qualitative improvements are required in the appraisal/ PDP system as this appears to be an important foundation for a TM system.

The literature⁽¹⁵⁾ and our informants stress that appraisal/PDP are an essential cornerstone of a TM system that brings together the

identification and development of talent. However, many of our informants consider that these processes tend to be rather marginalised and under-developed in the NHS, with the result that their potential contribution to TM is not realised.

5. Supply and demand (SFC) figures need to be refined. On the one hand, the demand figures may be too high (N+2 appears more accurate than N*3). On the other hand, the figures for talent pools may be too high.

It is broadly recognised that the first attempt to generate SFC are rather crude. In quantitative terms, it appears that the NHS may be more SFC than it appears as there seems to be a basic mathematical flaw in the SFC calculations in that the target of three qualified interviewees for each senior post requires N+2 rather than N*3 interviewees. On the other hand, the NHS may be less SFC than the figures suggest as the composition of talent pools have not yet been robustly tested, with a feeling that people that have successfully completed 'Aspiring' courses may not be ready for posts, and that the figures in different SHA plans may not be comparable as they are using rather different definitions of 'ready now' and 'ready soon' status.

6. Continue the stress on clinical leadership, but clearer guidance is required on aspirations on the proportion of clinicians and doctors in senior management.

Recent documents have continued to stress the importance of clinical leadership^{(14); (123)}. According to the King's Fund Commission on Leadership and Management, leadership development needs to extend 'from the board to the ward'. One of the defining weaknesses of the NHS over the decades has been the lack of involvement of clinicians in management. However, the targets in SHA plans vary significantly.

7. Continue the stress on increasing the diversity of leadership, but clearer guidance is required on whether aspirations should reflect workforce or population, and – in line with the Equality Act 2010- greater stress should be placed on other dimensions such as disability.

Both DH and SHA documents are unclear about whether senior management should reflect the broader workforce or the population served. This is important as this is based on rather different conceptual justifications and lead to rather different targets (for example, roughly 70% or 50% in terms of females). Moreover, equality and diversity concerns in the NHS have traditionally been focused on race and gender, resulting in other dimensions such as disability and sexuality being neglected. Although some progress has

been made (e.g. Single Equality schemes), significant further work is required to comply with the 2010 Equality Act.

8. Broaden the activities that constitute TM to place greater stress on wider development activities including coaching, mentoring, formal/informal study programmes, job rotation.

The literature is far from clear about the 'return on investment' (ROI) associated with the different elements of TM. The King's Fund Commission on Leadership and Management⁽¹⁴⁾ claims that we know remarkably little about the most enduring and well-regarded investment in the NHS management workforce has been the NHS, the flagship MTS scheme in terms of the subsequent career trajectories of its graduates or about how well it meets the needs of the NHS (but see: ^{(168);(169)}). While training is important to organisational performance⁽¹⁵⁾ in the absence of a greater volume of clear evidence, it may be best not to place all of the TM eggs in the formal 'courses' basket, and draw on some of the other elements such as coaching and mentoring.

9. More stress on developing joined up systems to plan, record, and track talent is required.

As the NHS has not invested in a single TM database, SHAs tended to develop their own with varying degrees of sophistication. However, our interviewees tended to stress the importance of a single database, or at least compatible databases that would enable greater comparability between talent pools.

10.6 *Suggestions for further research*

The recommendations for future research, listed in order of priority are:

1. a cost/benefit evaluation for development activities (rather than just courses) beyond 'Kirkpatrick level 1'⁽¹⁷⁰⁾: for example, should more investment go to ALS rather than formal courses?

This relates to Recommendation 9 (above). Although there have been some attempts to determine ROI (e.g. ^{(168); (169)}), many evaluations focus on 'Kirkpatrick level 1' or 'happy ticking', asking participants whether they felt that they benefited from the course, often using Likert scales. However, these results are rarely compared in terms of benefit, and very rarely in terms of cost. This results in it being far from clear whether some formal courses give a greater return than others, or whether other activities such as ALS provide a better return than formal courses.

2. an exploration of the effects of reorganisation on talent and diverse leadership.

A good deal of largely anecdotal evidence (e.g.⁽¹⁰¹⁾) suggests that previous reorganisations in the NHS have had negative implications for diverse leadership. Given recent efforts to increase diverse leadership (NHS Institute, NLC, Equality and Diversity Council, NHS Constitution, Equality Act), an investigation of whether the current reorganisation is having similar effects is suggested.

3. an exploration of how appraisal/PDP links to organisational performance

It has been suggested by our interviewees that appraisal/PDP may be one of the 'weak links' in TM (see Recommendation 4, above). This fits with the finding of West et al⁽¹⁵⁾ that having well-structured appraisals (where clear objectives are set, the appraisal is helpful in improving how to do the job, and the employee is left feeling valued by their employer) is particularly important to organisational performance. Given this, it is possible that a project that finds ways of improving a process with much room for improvement might result in significant improvements in TM overall.

4. a realistic/ contextual evaluation of TM

It has been found that much of the evidence base on TM is limited. In particular, evidence of effectiveness is far from robust, often relying on anecdote, reportage and brief case studies(7). Moreover, much of the literature relates to the 'for profit' sector in the USA, using dependent variables such as share value. It is far from clear that such results are transferable to the British NHS. In this situation, a project that uses realist approaches to develop 'context-mechanism-outcome configurations' or 'programme theory' for the NHS is suggested.

5. an evaluation of different approaches to TM (e.g. Academies) given future likely differentiation (natural laboratory).

As any future TM initiative appears to be based on employing organisations, this gives rise to an opportunity to determine the extent to which the resulting differing approaches are effective. This might involve an examination of whether organisations that place more stress on TM are associated with superior organisational performance, or whether different approaches (e.g. the Academy model) are associated with superior organisational performance. Moreover (related to 4, above), it is possible that some approaches may be associated with greater effectiveness (eg larger talent pools) while others may be associated with greater equity (eg more diverse leadership).

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Appendix 1

Project Summary

The Health Services Management Centre Project – Birmingham University:

Talent Management in the NHS Managerial Workforce

Main Aims & Objectives

The main aim of the research is to identify the impact of talent management approaches to the development of an effective NHS managerial workforce. The research will focus on five objectives:

1. to examine the career trajectories of four managerial cohorts;
2. to examine the facilitators and barriers to talented individuals achieving their potential;
3. to evaluate the impact of different Talent Management (TM) and earlier 'managing talent' (mt) schemes on individuals;
4. to explore how values, motivations and beliefs link with managerial careers;
5. to examine how TM links with organisational success.

Research Schedule

Stage 1 – Set-up: March to September 2009

ethics approval; recruit full-time research fellow; advisory group; begin literature review.

Stage 2 – Literature review and focus group: August to November 2009

research governance at UHNS; complete literature review; arrange and complete focus group of local senior and middle managers (n = minimum of 10) at UHNS – to identify experiences, themes and trends.

Stage 3 – National & regional interviews: November 2009 to April 2010

interviews with senior national and regional managers with responsibility for TM (n = 15-20) – focusing on policy aims, success measures, implementation problems and lesson learning.

Stage 4 – Interviews with 4 cohorts of managers: March to May 2010

interviews with four cohorts of managers (n = 4*15 = 60) – cohorts based on those who entered the NHS (a) before Griffiths; (b) during the General Management period (1983-89); (c) during 'quasi-market' period (1990-1997) and during New Labour collaborative market era (1997-) – to focus on values, motivations and beliefs; employment histories; key decisions and moments; experience and evaluation of any mt (before 2004) and TM (post-2004); interim report to SDO.

Stage 5 – Survey of 4 cohorts of managers: June to October 2010

a survey of around 2000 managers from the four cohorts of managers – basic career histories and experiences of TM and mt.

Stage 6 – Five high performing organisations: August to October 2010

identification of five different types of high performing organisation – PCT; acute Trust; Foundation Trust; Mental Health Trust; Ambulance Trust; research governance at each site; questionnaire survey (n = 50) and interviews (n = 8) of managers at each site – to focus on individual managers' experience of TM and organisational success.

Stage 7 – Focus group: November to December 2010

second focus group at UHNS – to discuss the results from the highly performing organisations and to ensure that the preliminary findings from the study are useful to NHS managers.

Stage 8 – Report writing, publication and dissemination: January to February 2011

dedicated time to writing Final Report for SDO; followed by publication and dissemination.

Participating Organisations (agreed so far)

University Hospital North Staffordshire (UHNS).

Project Team

Professor Martin Powell

Dr Joanne Duberley

Dr Mark Exworthy

Dr Joan Durose

Dr Fraser McFarlane

Mr Chris Fewtrell

Dr Phil Moss

Participant Information Sheet (Focus Group)

Study title: Talent Management in the NHS Managerial Workforce

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The NHS has recently (2004) pulled together the elements of talent management under the responsibility of one initiative, the NHS Talent Management team. It has identified that 'good leadership at every level' is a significant factor in improving the quality of patient care and the health of the population. It also set out the importance of a systematic and stretching talent management system for clinicians and managers. Even before first use of the term talent management in 2004 and before 'general management' in 1983, there has always been a range of programmes and support for aspiring administrators and managers. For example the Management Training Scheme (previously known as the Graduate Training Scheme) is now 50 years old.

This research project aims to examine:

- the managerial career trajectories of groups of managers in the NHS;
- the promoters and barriers to talented individuals achieving their potential;
- the impact of different talent management schemes;
- how talent management links with organisational success.

Who has reviewed the study?

The project has been reviewed by the National Institute for Health Research Service Delivery and Organisation which has approved and agreed to fund it. It has also been submitted to a National Research Ethics Service Local Research Ethics Committee and the University of Birmingham Ethics Committee for their approval.

Why have I been chosen?

We are seeking to recruit managers (with or without a clinical background) who have worked within the NHS over the last 25 years. Participants have been recruited through personal contacts of the researchers using a 'snowball' approach.

What does participation in the study involve?

If you agree to participate, we would like to invite you to a focus group session on the following topics:

- your career history and the facilitators and barriers to your managerial development;
- rank a range of key issues associated with talent management and then discuss in group those ranking decisions;
- review and then discuss in group draft interview and survey questionnaire schedules intended to be used on the project.

The focus group, which will comprise up to 10 NHS managers from the local area, should take approximately two hours in total. You will be asked if you are happy for the session to be tape-recorded

prior to the start. You may ask for any sensitive remarks to be withdrawn from the record and may withhold any information which you regard to be of a sensitive nature. As a participant, you are under no obligation to take part in this research. Refusal to do so will have no impact on your career in any way. You have the right to withdraw from the study at any time, and if you do so, the information you have provided will not be used and any record of that data will be destroyed.

What happens if something goes wrong?

Participation in this project carries very little risk of psychological or physical harm.

If you wish to complain about any aspect of this study, you should contact the research sponsor's representative: Dr James Wilkie, Director of Research and Commercial Services, University of Birmingham (email: j.h.wilkie@bham.ac.uk; ☎: 0121 414 9090). The research will operate under the University of Birmingham indemnity insurance scheme which covers negligent acts.

Confidentiality

All data collected within the project will remain confidential. This includes data from the focus groups and any documentation that is not in the public domain, as well as any informal discussions. Individual respondent's names or any identifying details will not be made available in any publication or to any other organisation or individual. Please note that all those involved in the study have the right to request that anything they regard as sensitive or confidential (verbal or written) be excluded from the study.

In keeping with guidelines for good research practice, all data collected will be anonymised. The data will be stored for a period of at least five years within a locked filing cabinet within the research establishment and under the care of a designated custodian. All data will be stored in accordance with the Data Protection Act, 1998 in locked cabinets at the University of Birmingham. At the end of the five year period, all focus group notes, tapes and other pieces of data relating to the project will be destroyed.

Anonymous abstracts from participants comments recorded during the focus group session, may be used in the final report and any publications resulting from this study. Given the potential sensitivity of this research and the very remote possibility that selected quotes made by individuals and used in publications may be attributable to them, you are free to withdraw at any stage or refuse to answer specific questions. If you withdraw, your data will not be used.

Feedback and dissemination

We will feed back results of the project to those who have been directly involved. This may take the form of a summary report once all phases have been completed. It is planned to publish an academic paper in a peer reviewed journal detailing the findings of this study.

Contact for further information

If you have any queries or concerns regarding the project please contact:

Professor Martin Powell
Health Services Management Centre
University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham B15 2RT
☎: (0121) 414 4462
email: m.powell@bham.ac.uk

Talent Management in the NHS Managerial Workforce

Consent Form

- | | Please
tick |
|--|--------------------------|
| • I the undersigned voluntarily agree to take part in the study on Talent Management | <input type="checkbox"/> |
| • I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. | <input type="checkbox"/> |
| • I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved. | <input type="checkbox"/> |
| • I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. If I withdraw from the study, I understand that my data will not be used. | <input type="checkbox"/> |
| • In the event of needing to complain, I understand that I should contact Dr James Wilkie, Director of Research and Commercial Services, University of Birmingham (email: j.h.wilkie@bham.ac.uk ; ☎: 0121 414 9090) | <input type="checkbox"/> |
| • I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study. | <input type="checkbox"/> |

Name of volunteer (BLOCK CAPITALS)

Signed

Date

Name of researcher/person taking consent
(BLOCK CAPITALS)

Signed

Date

Appendix 2

Table A.1: Spoilt for Choice Analysis

	SC CERN CERS DRN DRS	Spotting Current: Pool CE Dir	Clinicians	Communities: BME	Communities: Women	Communities: Disabled People	Staff Survey
EE	Based on 2 candidates CERN: +9/ but +2 for 3 DRN: +9, but -30 for 3 (RAG 2.2)	RN+RL 41:86 224:308	RNCE: 13% Clin RNCE: 13% Doc RND: 14% Clin RND: 10% Doc DTCE: 13% Clin DTCE: 3% Doc DTD: 27% Clin DTD: 18% Doc	RNCE: 5% RND: 5% DTCE: 3% DTD: 4%	RNCE:33% RND: 36% DTCE: 38% DTD: 49%	RNCE: 0% RND: 3%	Oppor: 42% (nat av 45) TLD: 81% (81%) App: 27% (28%) PDP 54% (57%) Support: 3.64 (3.63)- graph !!!!!!!
EM	RNCE: +12 RSCE: +7 RND: +8 RSD: -27	1.54 1.42	RNCE: 33% Clin RNCE: 17% Doc RSD: 27% Clin RSD: 5% Doc	RNCE: 0% RND: 6%	RNCE: 56% RND: 49% + details	No data	Graph (circa) Supported PDP: 57% PDP: 88% App: 62% RAG = red- worst 40% of SHA
L	CERN: 12/36/27/9 CERS: 66 (existing)/ 198/79/ 119 DRN: 92/276/82/194 DRS: 286 (in post)/ 276/ 271/5	Not given	CERN: 37% (C); 7% (M) CERS: 36% (C); 8% (M) DRN: 29% (C); 19% (M) DRS: 34% (C); 14% (M)	CE and Directors: Target: 157 Gap: 117 (based on 45% workforce)	CERN: 54% F DRN: 61% F (based on 50:50 - population?)	No data	Not given

Table A.1: Spoilt for Choice Analysis: continued ...

	SC CERN CERS DRN DRS	Spotting Current: Pool CE Dir	Clinicians	Communities: BME	Communities: Women	Communities: Disabled People	Staff Survey
NE	No 3x demand? CERN: 1/7/+6, but 3/7/+4 CERS: 3/10/+7, but 9/10/+1 DRN: 13/14/+1, but 39/14/-25 DRS: 39?/22?/ 17? But 117/ 22/ -95	CE: 1 in 0.52? D: 1 in 0.18?	CERN: 3/7 clin DRN: 6/7 clin CERN: 0 doc DRN: 1 of 14? Doc CERS: 1 of 10? Clin C DRS: 5 of c22? Clin CERS: 1 of 10? Doc DRS: ?	CERN: 0 DRN: 2% (close to regional community percentage)	Numbers or %? CERN: 4 DRS: 10 (10 in 12- ie N not %)	No data	KSF development review: 41% (2007); 51% (2008) PDP as part of KSF DR: 91% (2007); 91% (2008) TLP: 52% (2007); 50% (2008)
NW	+8/RAG 4.0 +20/RAG 5.5 +2/RAG 3.1 +9/RAG 3.3	64:76 384:191	Only CE Target- 50% Desired- 24 CEO RN- 12 Clin-7 Gap- 5 Doctors Target-6 Doc-1 Gap-5	RN and RS CE and Dir T (6%): 20/16/gap4 T(11%): 30/20?/10	CE RN T (46%): 152/125?/22 T(77%): 152?/ 209? Med?/ surplus 57?	CEO RN T(3%): 1/1/0	No data
SEC	+5 -18 RS- graph but figures not given	RN +RL 26/ x1.9 Ratio: 0.8	CE+D 14% clin 16% med Total: 30% Target: 25%	RNCE: 0% RSCE: 5% RND: 10% RSD: 3% (6% pop; 24% staff)	Graph: circa RNCE: 30% RSCE: 45% RND: 42% RSD: 44% (pop 51%; staff 75%)	No data	Graph: circa App/PDP: 50% TLD: 82% Support: 70%
SC	?	N	N	N	N	N	N
SW	SC: CE RN Not SC: others	Current: Pool CE- 41:52 Dir-175:181	C/D Current: 22/4.9 5 year goal 50/- RN/RS CE 2.9/0.4 RN/RS Dir: 6.4/7.7	Current/Goal/RN/RS 2/9/0/0	41/78/2/5	No data	A/PDP: 57 TLD:54 S: 58

Table A.1: Spoilt for Choice Analysis: continued ...

	SC CERN CERS DRN DRS	Spotting Current: Pool CE Dir	Clinicians	Communities: BME	Communities: Women	Communities: Disabled People	Staff Survey
WM	CERN: 24/5/ -19 CERS: 48/15/ -33 DRN: 141/22/-119 DRS: 282/22/ -260	Pool/CE 0.42 Pool/Dir: 0.15	Clin: 25%; current CE 6%; RN 20%; RN+RS 20% Doc: goal- 25%; current 2%; RN 20%; RN+RS 20%	Goal- 11%; current 0/ CERN 20%; RN+RSCE: 12%	Goal- 50%; current- 39%; CERN 40%; RN+RS CE 50%	Goal- 5%; current: CERN, CERN + RS- all 0%	App+ PDP: 61% TLP: 31% Support: 34%
YH	CERN: 4/12/24- gap +20 (+12?) CERS 8/24/ 41/ +33 (+17) DRN: 16/48/88/+72 (+ 40) DRS: 37/111/210/+173/ + 99 Gives ratio of candidates to vacancy rather than RAG, but all more than 3:1.		Clinicians CERN: 50% CERS: 32% DRN: 47% DRS: 40%	CERN: 0 CERS: 4.6% DRN: 0.6% DRS: 9.5%			App: 63% App/PDP: 55% Well structured App: 27% Opp: 46% Training: 81%

Table A.2: SHA Programmes and activities

Programme	EE	EM	L	NE	NW
Aspirant CE	HPEP (2008-21; current- 14)	Y	Next Generation CE (2008- 35; 2010-20)	Y	Y
Aspirant Director	Y (2008-90; current- 122)	Sept 2009, with 2 nd cohort Dec 2009	Next Generation Director (Autumn 2009 launch)	Y (CE and Director - total 49)	Y
Other Leadership			Future Commissioning Director; Building NHS London Future Talent (Band 7 and above); Workforce for London Transformation Development Programme; Masterclasses;	Nurse Director development programme (12); Finance skills/ director development (20)	Range of programmes; Regional Emergent Leaders schemes; Executive stretch programme; Aspiring Directors of Public Health
Strategic Alliances					
Leadership Communities	Alumni				Alumni/ networking
Diverse Leadership	Regional BME conference; 2 network events	Emerging Leaders Programme	BME Summit; Mentoring for Diversity; BME social networking study		Y

Table A.2: SHA Programmes and activities: continued ...

Programme	EE	EM	L	NE	NW
Clinical Leadership	Senior Clinical Leaders Programme (2008-6; current- 94); CLN	CLF (8). Commissioned LD programme (120)	Darzi Fellowship (39); Prepare to Lead (2009-25) Clinical Leaders Network (60); Aspiring Nurse Director Programme; Clinical Alumni		CF Programme
Coaching/ Mentoring	Y	High quality executive coaching (75); Supporting mentoring course (4 days); Regional Mentoring Framework	Coaching Register	Establishing coaching and mentoring register	
Research Activity			BME social networking study		

Table A.2: SHA Programmes and activities: continued ...

Programme	SC	SEC	SW	WM	YH
Aspirant CE	Y		Y, Top Leaders (cohort 1: 22; 6 cohorts planned)	Y: ELD (cohorts 1 and 2: 29; cohorts 3 and 4: 34)	1 cohort (24). Future programme planned for 2010
Aspirant Director	Y	Cohorts 1 and 2 (52)	Y: Top Leaders	Y: Top Leaders (4 cohorts of 22 each in 2009/10)	2 cohorts establishing talent pool of 133
Other	Aspiring WCC for PCT CE; Leading for quality; range of programmes (over 3500 staff). 2008/9-11% staff, and by 2013 80% staff engaged in LD	Executive Directors programme (31 on 3 day)	Comprehensive programme; Aspiring DPH; targeted support for Directors or AD of HR; targeted support for commissioners; Medicine Management leaders; planned master classes for CE	Aspiring Nurse Director; Aspiring HR Director; Director internships;	Fostering Leadership and Management Excellence: Mid level, used to pull through more diverse leaders from clinical and BME backgrounds: 592 participants over 4 years
Building Strategic Alliances					Learning partnership with Jonkoping in Sweden; Alliance with Common Purpose
Building Leadership Communities	Leadership development faculty (400; 2013 target of 1000); Alumni		Alumni	WCC 'communities of learning'; master classes; 2 leadership events for CE;	Master class series; Leadership conference planned

Table A.2: SHA Programmes and activities: continued ...

Programme	SC	SEC	SW	WM	YH
Building Diverse Leadership		BME master classes (200); developing Bespoke BME Leadership programme	Inclusion 100 initiative for BME staff: LD, mentoring and networking	4 CE have started pilot co-mentoring scheme	Innov8 Project; creation of BME talent pool; piloting of diversity leaders programme; generation of diversity alliance; mentorship programme
Building Clinical Leadership		CLN (90); Fit to Lead CL programme (52)	CLF (10); CLN (120)	CLN; CLF; F1 management programme; MSc in Medical Leadership	Clinical Leaders Network (120)
Building Coaching/ Mentoring/ ALS		20 Coaches on database	Register of Qualified Coaches; ALS	Coaching: web based matching tool; PCT mentoring	Trained development consultants; mentor database (100)
Research activity	Research and evaluation arm; number of studies		Project on competencies (Neil Goodwin); programme impact evaluation		CE

Table A.3: SHA Barriers and Risks

	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH
National										
Doctors continue to move to leadership due to fears about job security and insufficient incentives		x								
If successful, more doctors in leadership will have detrimental effect on gender balance		x								
Development of leadership programmes by profession						x				
FT fail to engage in regional programme						x				
Operational pressures take priority over leadership development						x		x		
UK economic climate							x	x		
Potential change in government in the next 12 months							x			
Evolving relationship between NLC and NHS III may lead to duplication or conflict								x		
Quality of information in ESR is variable								x		
Lack of agreed standards, criteria or competencies								x		
NLC does not drive a strong culture of subsidiarity (L/H)									x	
Not enough work done on setting appropriate market conditions and incentives (L/M)									x	
Workforce streams set agendas which are not relevant to local context (L/M)									x	
Assurance process turns into a performance management metric and tick box exercise (M/H)									x	
Expectations that talent pools of CE can be created in unrealistic timescales (M/H)									x	

Table A.3: SHA Barriers and Risks: continued ...

Regional	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH
NHS fails to tap into the talent of all the communities		x								
Potential duplication of provision by SHA and individual organisations						x				x
Economic circumstances reduce investment in leadership development						x			x	
Insufficient planning leads to lack of appropriate candidates for CE roles						x				
Disagreement by stakeholders on delivery methods for leadership developments						x				
Level of personal investment and job 'life expectancy' deter applicants for CE posts						x				
Some BME and talent planning programmes are viewed unfavourably by non BME staff						x				
Leadership development must not become divorced from the developing QIPP strategy (H/H)								x	x	
Trusts, especially FT, may be unclear about the role and function of the SHA as system leader or manager of the market								x		
Competing demands and pressures on resources means potential for the leadership initiative to become lost in a return to the default thinking around resources and targets								x		
TM processes can be seen as divisive (M/H)									x	
Plan becomes a tick box exercise on populating the Dashboard (M/H)									x	
Duplication of professional development and LD activity (M/L)									x	
Future financial constraints will cut funding for training (M/H)									x	
QIPP activity dominates the agenda for CE and LD is seen as lower priority (H/H)									x	
PCTs and providers do not provide or update workforce and recruitment data (H/M)									x	
Changes in pension provision and incentives or reorganisation create conditions for retirement of talent or 'brain drain' (L/M)									x	

Table A.3: SHA Barriers and Risks: continued ...

Local	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH
Limited or no funding within organisations for TM and LD							x			
SHA leadership plan delivers in isolation to other SHA organisations							x			
Limited sector partnerships developed across the public and private sectors to enhance leadership capability							x			
Limited current organisational infrastructure to deliver on talent and leadership development							x			
Poor or underdeveloped organisational profile of TM and LD resulting in lack of time and commitment of time and resources by the top team within organisations							x			
Organisations in financial recovery resulting in reduced contributions from directorate budgets							x			
Commissioning organisations to ensure Board members and very senior leaders share their knowledge and understanding of the healthy systems agenda with operational colleagues								x		
Perception of roles within a managed market								x		
Lack of strategic HR capacity								x		
TLD only embryonic in most organisations								x		
Available investment may not be targeted consistently and staff do not receive agreed development								x		
Workforce data is not routinely used to create evidence for workforce development, ESR perceived as poor quality; and NHS Staff Survey not adequately used.								x		
FT do not engage in the talent agenda (M.H)									x	
Uni-disciplinary approaches to development are favoured over multi-disciplinary (L/M)									x	
Publicity around removal of CE and future financial constraints may deter talented individuals									x	

from applying for CE posts (M/M)										
Lack of clarity around local/ regional/national responsibilities for talent and leadership (L/M)									x	

Table A.3: SHA Barriers and Risks: continued ...

Unclear, Not given or multi level	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH
Talent profiling diagnostic process masks the true level of supply for larger, more complex roles		x								
TM process not sufficiently objective and consistent		x								
Insufficient supply of PH professionals		x								
Alignment to NLC work streams (L/H)	x									
Fair and equitable access to leadership development (L/H)	x									
Insufficient coaches to support behavioural change (L/H)										
Raised expectations about what the SHA can deliver (L/H)	x									
Insufficient workforce data from organisations (L/H)	x									
Insufficient places on programmes to meet demand (L/H)	x									
Lack of suitable leadership providers (L/H)	x									
Low identification and recruitment to development pathways (L/L)	x									
Limited national support for regional approach (L/L)	x									
'Brain drain' and changing workforce demographics (H/H)	x									
Unable to track talent (H/H)	x									
Limited organisational development and workforce plans (H/H)	x									
Limited commitment and 'buy in' to invest in leadership development (H/H)	x									
Reduced leadership and talent pools (H/H)	x									

Economic climate (H/H)	x									
Organisations reluctant to release staff (H/H)	x									
Lack of clarity about local, regional and national responsibilities for leadership and TM (H/H)	x									
Duplication of commissioning – national, regional and local (H/L)	x									

Table A.3: SHA Barriers and Risks: continued ...

Unclear, Not given or multi level; continued ...	EE	EM	L	NE	NW	SEC	SC	SW	WM	YH
Conflicting strategies at local and regional level (H/L)	x									
Poor preparation of leadership pool- undergraduate/ pre-registration (H/L)	x									
Professional entrenchment (H/L)	x									
Investment in current climate (H/H)			x							
Lack of talent movement across system (H/H)			x							
Lack of clarity around roles (H/H)			x							
Individual organisations fail to engage with NHS London (L/L)			x							
Insufficient or un-sustained support at national level (L/L)			x							
Resistance to change (H/L)			x							
Conflicting strategies and timescales at regional and local level (H/L)			x							
Talent agenda not given sufficient priority (L/H)			x							
Significant talent gaps remain for critical roles in short term (L/H)			x							
Insufficient numbers of individuals have access to development programmes (L/H)			x							
Initiatives to increase representation of clinical and BME candidates fail (L/H)			x							

Key: Probability and impact respectively: HM or L (where given): i.e. (H/L) = high probability and low impact

Appendix 3

Talent Management in the NHS Managerial Workforce

Interviews with senior stakeholder/national and SHA managers

Interview question schedule:

- 1 Please describe your current role.
- 2 How long have you been at the organisation?
- 3 How long have you been in your current role?
- 4 What was your previous role?
- 5 Please describe your interest and involvement in:
 - a) leadership development;
 - b) talent management initiatives within the NHS
- 6 From your perspective how did the current TM approach come into being?
 - a) probe about the various elements of MTS, Gateway and Breaking Through
- 7 How is the current TM process different from initiatives which have occurred in the past?
 - a) what aspects of previous approaches worked well?
 - b) what aspects didn't work so well?
- 11
- 8 What are the current issues in leadership and talent management that need solving?
 - a) how would you like to see them resolved?
- 9 What is your experience/knowledge of other TM systems operating in health/public sector/private sector?
- 10 Please explain how management talent can be best identified?
- 11 Please explain how (once identified) management talent can be best developed?
- 12 What are the issues facing the NHS on retention of talent?
 - a) how will the TM process address these?
- 13 How will the system link individual development with organisational success?
- 14 What were/are the challenges in setting up the current TM system?

- 15 How have these been addressed?
- 16 What is the role of leadership competences in this process?
- 17 What are the challenges facing TM processes in the current economic climate?
- 18 Is there anything else that you feel that is important that we haven't covered?

❖THAN YOU FOR TAKING PART IN THE STUDY❖

Participant Information Sheet (Senior stakeholder/national and SHA Interviews)

Study title: Talent Management in the NHS Managerial Workforce

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Talent management has been defined as ensuring the right person is in the right place at the right time and is a deliberate and systematic effort by an organisation to ensure leadership continuity in key positions and encourage individual advancements. The NHS has recently (2004) pulled together the elements of talent management under the responsibility of one initiative, the NHS Talent Management team. It has identified that 'good leadership at every level' is a significant factor in improving the quality of patient care and the health of the population. It also set out the importance of a systematic and stretching talent management system for clinicians and managers. Even before first use of the term talent management in 2004 and before 'general management' in 1983, there has always been a range of programmes and support for aspiring administrators and managers. For example the Management Training Scheme (previously known as the Graduate Training Scheme) is now 50 years old.

This research project aims to examine:

- the managerial career trajectories of groups of managers in the NHS;
- the promoters and barriers to talented individuals achieving their potential;
- the impact of different talent management schemes;
- how talent management links with organisational success.

Who has reviewed the study?

The project has been reviewed by the National Institute for Health Research Service Delivery and Organisation which has approved and agreed to fund it. It has also been submitted to a National Research Ethics Service Local Research Ethics Committee and the University of Birmingham Ethics Committee for their approval.

Why have I been chosen?

We are seeking to recruit managers (with or without a clinical background) who have worked within the NHS over the last 25 years. Participants have been recruited through personal contacts of the researchers using a 'snowball' approach.

What does participation in the study involve?

If you agree to participate, we would like to interview you on the following topics:

- **career history;**
- **involvement in talent management;**
- **links between talent management and career progress;**
- **links between talent management and organisation success.**

The interview should not take longer than 60 minutes to complete and you will be asked if you are happy to be tape-recorded prior to interview. You may ask for any sensitive remarks to be withdrawn from the record and may withhold any information which you regard to be of a sensitive nature. As a participant, you are under no obligation to take part in this research. Refusal to do so will have no impact on your career in any way. You have the right to withdraw from the study at any time, and if you do so, the information you have provided will not be used and any record of that data will be destroyed.

What happens if something goes wrong?

Participation in this project carries very little risk of psychological or physical harm.

If you wish to complain about any aspect of this study, you should contact the research sponsor's representative: Dr James Wilkie, Director of Research and Commercial Services, University of Birmingham (email: j.h.wilkie@bham.ac.uk; ☎: 0121 414 9090). The research will operate under the University of Birmingham indemnity insurance scheme which covers negligent acts.

Confidentiality

All data collected within the project will remain confidential. This includes data from interviews and any documentation that is not in the public domain, as well as any informal discussions. Individual respondent's names or any identifying details will not be made available in any publication or to any other organisation or individual. Please note that all those involved in the study have the right to request that anything they regard as sensitive or confidential (verbal or written) be excluded from the study.

In keeping with guidelines for good research practice, all data collected will be anonymised. The data will be stored for a period of at least five years within a locked filing cabinet within the research establishment and under the care of a designated custodian. All data will be stored in accordance with the Data Protection Act, 1998 in locked cabinets at the University of Birmingham. At the end of the five year period, all interview notes, tapes and other pieces of data relating to the project will be destroyed.

Anonymous abstracts from interviews may be used in the final report and any publications resulting from this study. Given the potential sensitivity of this research and the very remote possibility that selected quotes made by individuals and used in publications may be attributable to them, you are free to withdraw at any stage or refuse to answer specific questions. If you withdraw, your data will not be used.

Feedback and dissemination

We will feed back results of the project to those who have been directly involved. This may take the form of a summary report once all phases have been completed. It is planned to publish an academic paper in a peer reviewed journal detailing the findings of this study.

Contact for further information

If you have any queries or concerns regarding the project or would like to discuss your organisations participation as a case study site in more detail, please contact:

Professor Martin Powell
Health Services Management Centre
University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham B15 2RT
☎: (0121) 414 4462
email: m.powell@bham.ac.uk

Appendix 4

On-Line Survey Questionnaire: Welcome Screen

Welcome to the Talent Management Survey Questionnaire.

This survey of NHS managers is part of a larger research project funded by the NIHR SDO Management Practice programme exploring Talent Management in the NHS. The project has obtained R&D approval for undertaking the research at the Trust.

Thank you for agreeing to complete the questionnaire, as your opinion matters to us.

You will be routed through the questionnaire depending on the range of questions you answer, and it should take no longer than 15 minutes to complete.

We would like to again recommend that it might prove useful for you to have a recent copy of your CV by your side as you complete the questionnaire.

Thank you,
The Talent Management Project Team.
HSMC, University of Birmingham

1. What is the full title of your current main job in the organisation?
Please enter your answer in the text box below. It will expand if necessary to accommodate your response.

2. Is this job your first job in the NHS?
Yes [if Yes respondent is routed to Q3]
No [if No respondent is routed to Q4]

3. In what year did you start this, your first job in the NHS?
Please select one only from the drop-down list.

Before 1983; 1983; 1984; 1985; 1986; 1987; 1988; 1989; 1990; 1991; 1992; 1993; 1994; 1995; 1996;
1997; 1998; 1999; 2000; 2001; 2002; 2003; 2004; 2005; 2006; 2007; 2008; 2009; 2010
Respondent is now routed to Q7

4. What was your first job in the NHS?
Please enter your answer in the text box below. It will expand if necessary to accommodate your response.

5. In what year did you begin your first job in the NHS?

Please select one only from the drop-down list.

Selection:

Before 1983; 1984; 1985; 1986; 1987; 1988; 1989; 1990;
1991; 1992; 1993; 1994; 1995; 1996; 1997; 1998; 1999; 2000; 2010

6. How many jobs have you had during your career in the NHS?

Please select your answer from the drop-down list and include your first and current job in the total figure selected.

1; 2; 3; 4; 5; 6; 7; 8; 9; 10; more than 10

7. Have you ever worked in a management role outside of the NHS?

Yes [if Yes respondent is routed to Q8]

No [if No respondent is routed to Q9]

8. Please provide details of your management jobs outside of the NHS – most recent first.

Please enter the job title, organisation and start date (4 digit year) for each post in the text boxes provided.

	Job Title	Organisation	Start Date (Year)
Job 1			
Job 2			
Job 3			
Job 4			
Job 5			
Job 6			
Job 7			
Job 8			
Job 9			

9. Has your management career to date included any breaks (e.g. child-rearing; caring duties, travel etc.)?

Yes [if Yes respondent is routed to Q10]

No [if No respondent is routed to Q11]

10. Please provide the following details for each career break:

Please enter the type of career break, the start date (4 digit year) and the end date (4 digit year) for each break in the text boxes provided.

	Type of break	Start Date (Year)	End Date (Year)
Break 1			
Break 2			
Break 3			
Break 4			
Break 5			

11. Could you please indicate your educational and work qualifications?

Please select all that apply.

<input type="checkbox"/>	None
<input type="checkbox"/>	'O' Level/CSEs/GCEs (any grades) – or equivalents
<input type="checkbox"/>	'A' Level/AS Level/Higher School Certificate – or equivalents
<input type="checkbox"/>	Degree Foundation Programme
<input type="checkbox"/>	First Degree (e.g. BA, BSc)
<input type="checkbox"/>	Higher Degree (e.g. Masters, PhD, PGCE)
<input type="checkbox"/>	NVQ Level 1
<input type="checkbox"/>	NVQ Level 2
<input type="checkbox"/>	NVQ Level 3
<input type="checkbox"/>	NVQ Level 4
<input type="checkbox"/>	Other vocational qualifications
<input type="checkbox"/>	Qualified Medical Doctor
<input type="checkbox"/>	Qualified Nurse, Midwife, Health Visitor
<input type="checkbox"/>	Qualified Paramedic
<input type="checkbox"/>	Qualified Therapist (e.g. physio; OT; speech & language; psychology)
<input type="checkbox"/>	Other

12. Have you undertaken any professional management development activities / programmes you have undertaken during your NHS management career?

Yes [if Yes respondent is routed to Q13]

No [if No respondent is routed to Q22]

13. Please indicate the professional management development activities / programmes you have undertaken during your NHS management career.

Please select all that apply.

National Graduate Management Training Scheme
 National / Regional Breaking Through Programme
 National / Regional Gateway Programme
 Current / Aspiring Chief Executive Programme
 Aspiring Director Programme
 Senior Management Programme
 Leadership Fellowship
 Clinical Leadership Fellowship
 General Management Programme
 International Management Programme
 Coaching
 Mentoring
 Secondment – with a training / stretching remit
 Action Learning Sets
 Other short courses (e.g. writing/presentation skills; finance)

 Other – please specify

14. What were the main facilitators which enabled you to undertake the professional management development activities you have identified?

- such facilitators could range from self-motivation and familial support, through opportunistic availability, to peer or senior manager support.

Please enter your answer in the text box below.

It will expand if necessary, to accommodate your response as you type.

15. Did you face any barriers or obstacles either in obtaining your chosen training or once on the programme or activity?

Yes [if Yes respondent is routed to Q16]

No [if No respondent is routed to Q17]

16. Please describe the nature of the barriers or obstacles you have faced in the text box below.

It will expand if necessary, to accommodate your response as you type.

17. Were the programmes or activities of value to you in terms of developing your management career?

Yes [if Yes respondent is routed to Q18]

No [if No respondent is routed to Q19]

18. Would you please give further details of how the programmes activities were of value in your managerial career in the text box below?

It will expand if necessary, to accommodate your response as you type.

Respondent is now routed to Q20

19. Please describe their shortcomings in the text box below?

It will expand if necessary, to accommodate your response as you type.

20. Are there any other type of schemes, activities or development elements which would have helped you to develop your career in the NHS?

Yes [if Yes respondent is routed to Q21]

No [if No respondent is routed to Q25]

21. Would you please describe the schemes, activities or development elements which would have helped you develop your career in the NHS in the text box below.

It will expand if necessary, to accommodate your response as you type.

22. Have you considered undertaking professional management development during your managerial career/

Yes [if Yes respondent is routed to Q23]

No [if No respondent is routed to Q24]

23. Could you please describe in the text box below what circumstances have prevented you from pursuing professional management development?

It will expand if necessary, to accommodate your response as you type.

Respondent is now routed to Q25

24. Would you please describe in the text box below why you have not considered professional management development to date?

It will expand if necessary, to accommodate your response as you type.

25. Do you think the skill-set required by NHS managers has changed over time?

Yes [if Yes respondent is routed to Q26]

No [if No respondent is routed to Q27]

26. Please describe in the text box below how you think the NHS managerial skill-set has changed over time.

It will expand if necessary, to accommodate your response as you type.

27. Are you aware of the current initiative regarding Talent Management in the NHS?

Yes [if Yes respondent is routed to Q28]

No [if No respondent is routed to Q29]

28. What do you see as the strengths and shortcomings of Talent Management, and how do you think it could be improved?

Please enter your responses in the text boxes below.

If 'none' please enter in the relevant text box(es)

- What do you perceive as the strengths of the Talent Management initiative?
- What do you perceive as the shortcomings of the Talent Management initiative?
- What improvements would you like to see with respect to the Talent Management initiative?

29. Is there any other comment you would like to make?

Please enter your answer in the text box below.

It will expand if necessary, to accommodate your response as you type.

The Project Team would like to thank you for undertaking this Survey on Talent Management in the NHS.

To conclude the survey, we would like to obtain some personal details from you and request that you complete the standard Consent Form.

The completion of the Consent Form is mandatory in order for us to meet our Research Ethics requirements.

We are asking about some of your personal details in order to ensure we are able to accurately report on the profile of those completing this survey. You are not required to complete this section if you do not wish to.

CONSENT FORM

30. I have voluntarily agreed to take part in the study on Talent Management.

Yes
No

31. I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

Yes
No

32. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

Yes
No

33. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. If I withdraw from the study, I understand that my data will not be used.

Yes
No

34. In the event of needing to complain, I understand that I should contact Dr James Wilkie, Director of Research and Commercial Services, University of Birmingham (email: j.h.wilkie@bham.ac.uk; ☎: 0121 414 9090)

Yes

No

35. I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Yes

No

PERSONAL DETAILS

36. Would you please record your age as a two-digit number in the box below?

37. Would you please describe the following in your own words in the text boxes provided?

Your gender:

Your ethnic background:

38. If you would like to be informed about the results of this research and kept up to date about dissemination of findings, could you please supply your current email address in the box below.

THANK YOU.

We appreciate you taking the time to take our survey.

Thank you.

The Talent Management Project Team
HSMC, University of Birmingham

Appendix 5

Talent Management – Cohort Interview Schedule:

- 1) Obtain details of career history:
 - a) current job;
 - b) previous NHS jobs;
 - c) verify year began working in the NHS;
 - d) does respondent have a clinical background;
 - e) previous jobs outside the NHS, if any;
 - f) details of any career break – child rearing/caring – travel etc.
 - g) undertaken any secondments.
- 2) Obtain details of main post school educational qualifications.
- 3) Obtain details of any professional qualifications obtained.
- 4) What types of professional management development have you undertaken, if any – refer to listing and prompt:
 - a) National (Graduate) Management Training Scheme (any variant);
 - b) National Breaking Through Programme
 - c) National Gateway Programme
 - d) Current/Aspiring Chief Executive Programme
 - e) Aspiring Directors Programme
 - f) Senior Leadership Programme
 - g) International Management Programme – Europe; USA; Other
 - h) Leadership Fellowship
 - i) Clinical Leadership Fellow
 - j) General Management Programme
 - k) Coaching;
 - l) Mentoring;
 - m) Secondment (with a training/stretching remit);
 - n) Action Learning
 - o) 360 Degree Feedback

Those who undertook management / leadership development

- 5) What were the main factors that influenced you to undertake such development / training at the time?
- 6) How were you assessed to go onto the programmes/activities?
- 7) Did you face any barriers / obstacles obtaining the training / once on the programme/activity?
 verify - whether obtaining training or once on programme or both;
 verify - the specific barrier or obstacles
- 8) How would you describe your experience on the programmes/activities?
 tease out - positives / shortcomings of programmes/activities
- 9) How receptive were your managers to any requests/ideas for development?
- 10) Having undertaken these programmes/activities, what impact would you say they have they had on your career development, if any?
 tease out - negatives / positives
- 11) How were the programmes/activities that you pursued paid for?
- 12) Were there any other development programmes/activities available which would have been beneficial to you, but which you chose not to pursue?
 If Yes:
 which one's
 and why did you not pursue them
- 13) What schemes, activities or elements other than what were available at any given point in time, would have helped you develop your career in NHS management?
- 14) [where appropriate] what skills are necessary in today's NHS compared to those needed in the past?
 tease out – as they fit with current Leadership Quality Framework

Those who have not undertake management / leadership development

- 15) Have you ever considered undertaking such programmes /activities
 If Yes:
 why have you not pursued this avenue further
 tease out - what were the obstacles/barriers faced.
- 16) If No –

why not?

- 17) What, if anything, would encourage you to consider undertaking management and leadership training

Questions For All Respondents

Professional development appraisal

- 18) What form, if any, of professional development appraisal processes have you undergone during your work as a manager?

tease out – Leadership Quality Framework and 360-degree Assessment?

If Yes:

has the appraisal process been a regular feature of your working life?

how useful has the process of appraisal been to you?

could the process of appraisal be improved – how?

If none – how do you feel about that?

- 19) Do or have you had a role appraising and identifying other staff under your supervision for further professional development?

If Yes – could you please explain what that role has is / has been?

Values, beliefs & motivations

- 20) Why do you do the job that you are doing?

tease out: the values, motivations and beliefs underpinning those reasons?

- 21) When you look at your career to date what have been the pivotal moments and/or the pivotal people that have shaped your career?

- 22) And – why do you choose these particular moments as pivotal?

- 23) Have your values, beliefs and motivations as a manager changed as your career has progressed (through different roles and functions)?

tease out: why and how?

- 24) What is next for you on the NHS management career ladder?

- 25) What are your opinions/views on the current Talent Management programme?

tease out:

have you heard about it – what do you know about it?

what do you see as its strengths?

what do you see as its shortcomings?

how do you think it could be improved?

26) Do you plan to remain working in NHS management for the remainder of your working life?

If No:

why not?

where are you planning to move to?

and when are you planning to make this move?

27) What are your views about the reported high attrition / turnover rates of more senior NHS manager posts?

David Nicholson quoted as saying that NHS CEO spend on average of only 700 days in post;

recent Incomes Data Services report (Pay in the Public Services 2010) suggests that 1 in 5 NHS executives leave their job every year

tease out opinion on why: pay; hours; unrealistic demands ...

28) Is there anything else you would like to add?

this could be anything we have already covered,

or anything you think we may have omitted in our discussion.

29) Other Personal Details

Ask:

Age ;

How they would describe their ethnic origin

THANK YOU

Request completion of Consent Form – and details of how they wish to undertake this: by post with SAE envelope or scanned and email.

Appendix 6

Talent Management Project – HPT TM and Leadership Lead Interview Schedule

- could you please outline the aims of the Trust in terms of organisational development?
 - and – where does TM and leadership fit into that organisational development?
 - and – how important is TM and leadership within the Trust?
- what leadership/TM programmes or activities do the Trust currently have available for access by their staff?
 - go through and identify for the audio record.
- how long have these programmes and activities in been in place?
 - tease out which are relatively new which have been in place longer, which have been ‘refreshed’.
- are the new initiatives and any refreshments of older programmes due to the current TM/leadership initiative?
 - or a result of the developments within the Trust despite the TM/leadership initiative.
- what has been the Trust’s relationship with the TM/leadership initiative and the role of your respective SHA?
 - tease out issues, problems, where it has worked well;
- do they have a formal TM plan / framework and a TM process in place?
 - how is the Trust identifying its talented managers?
- is the Trust doing anything on how your professional development programmes and TM/leadership activities are impacting upon the success of the Trust?

- are there any criteria you are using for that evaluation or is it more informal and ad hoc?
- where do you think the Trust is in terms of its journey in relation where it wants to be with respect to TM and leadership development?
- are there any major new TM/leaderships initiatives for the Trust in the immediate future?
- and what do you perceive as the major issues that the Trust needs to address in order to fulfil its TM/leadership activity?

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. From January 2012, the NIHR SDO programme merged with the NIHR Health Services Research programme to establish the new NIHR Health Services and Delivery Research (NIHR HS&DR) programme. Should you have any queries please contact Hsdrinfo@southampton.ac.uk