Talent management for NHS managers: human resources or resourceful humans?

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The need for effective leadership in the UK public sector has been a prominent discourse in recent years. One aspect of this is a growing interest in talent management. This article examines the evolution of processes used for managing talent and developing leaders in the UK's National Health Service (NHS) by applying human resource management theory to an empirical case study. Our aim was to provide a constructive, but critical, analysis of the current role of managerial talent management and to comment on the suitability of the adopted approach in the NHS. Over the past three decades the NHS has come to adopt an increasingly 'hard' approach to talent management, i.e. rationalistic, managerial and narrowly focused on leadership competencies and senior management roles. This parallels a more general shift in the NHS from its traditional public sector ethos and humanistic values to more business-oriented values and ways of working.

Keywords: HRM; leadership; NHS; talent management; workforce planning.

The UK National Health Service (NHS) has long stressed the importance of management and leadership (Dopson, 2003; Iles, 2006; Peck, 2006). Indeed, its management training scheme is over 50 years old (Saunders, 2006). In the past decade, policy-makers have placed increasing emphasis on formal workforce planning (Dopson, 2003; Peck, 2006; Health Committee, 2007; DH, 2008a) and more recently talent management (Blass, 2007; Gander, 2008; Ford, 2010) as key strategies for ensuring that effective leaders are trained and can be put in place as needed. In this article we consider how approaches to talent management in the National Health Service (NHS) have moved between 'soft' and 'hard', and we question whether the latter approach, which often characterizes firms in the private sector, is fit for purpose when transported into a public sector context and public service ethos (a service providing free health care to every citizen on the basis of need).

Hard and soft HRM

The literature on human resource management (HRM) distinguishes between hard approaches based on 'utilitarian instrumentalism' and soft approaches based on 'developmental humanism' (Legge, 2005).

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 (Storey, 1992; Legge, 2005). In other words, humans and the skill base they bring are resources to be planned and managed in the same way as any other organizational resource. Hard HRM focuses on the importance of 'strategic fit', where HR policies and practices are closely linked to the strategic objectives of the organization (external fit), and are coherent among themselves (internal fit) (Baird, 1988; Hendry and Pettigrew, 1990), with the ultimate aim being increased competitive advantage.

In contrast, soft HRM is closely aligned with the high performance work systems (HPWS) approach. Becker and Huselid (1998) conceptualize HPWS as a set of distinct, but interrelated, HRM practices that together select, develop, retain, and motivate a workforce. Organizations are seen as investing in their pool of human capital to ensure that employees are well trained, skilled and

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empowered to conduct their jobs. The HPWS approach includes selective staffing, self-managed teams, decentralized decision-making, extensive training and management development, flexible job assignments, open communication and performance related pay. These elements are seen as interdependent in that the inclusion of one element requires the inclusion of the others.

Hard HRM can be thought of in terms of managing human resources (with the emphasis on resources), whereas soft HRM can be thought of in terms of developing resourceful humans (with the emphasis on humans). While soft HRM may have more positive ethical connotations, the private sector tends to adopt a hard HRM approach. Truss *et al.* (2003), for example, concluded that:

> *…the rhetoric adopted by private sector companies frequently claims to embrace the philosophy of the soft, commitment model while the reality experienced by employees is more concerned with strategic control, similar to the hard model.*

'Hard' and 'soft' talent management

Talent management is a subset of HR activity. At one extreme, 'talent' might refer to a narrow section of the workforce (such as senior leaders) and its 'management' to a narrow range of activities and processes tightly oriented to attracting and developing those individuals. At the other extreme, 'talent' might refer to the entire workforce and its 'management' to a wider range of activities and processes including motivating, rewarding and retaining staff (and hence blurs with the whole gamut of HR activities for the organization). Arguably, if talent management is to mean anything, its definition and scope must be at least moderately tightly focused.

There are many definitions of what makes a talented manager, including potential; achievement; ability to deliver the organization's strategy; leadership; and superior behaviour. The Chartered Institute of Personnel and Development (CIPD) has produced some broad definitions for both 'talent' and 'talent' management:

> *Talent consists of those individuals who can make a difference to organizational performance, either through their immediate contribution or in the longer term by demonstrating the highest levels of potential.*
>
> *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 organization* (CIPD, 2008).

In these definitions, 'talent' is seen as synonymous with 'talented individuals'. The language is striking, and implies that some people are more talented than others, hence more worth investing in, and that talent is an undifferentiated good. CIPD's recommended HR processes to support talent management include recruiting people with talent; rewarding talented recruits; organizing groups of talent (banks and pools); ensuring diversity of talent; appraising talent (and performance management); developing talented individuals; deploying talent; tracking talent; and retaining talent (CIPD, 2008).

While the CIPD (whose raison d'être is the development of individuals) advocates a soft talent management approach, other organizations align more closely with rationalist, instrumental (hard) talent management. They take as their starting point that talent (which is seen as abstracted from the people who possess it or might come to possess it) is an essential resource. Some argue that demographic and business trends mean that there is a shortage of talent, making this resource particularly valuable (Tucker, 2005). This approach has parallels with the resource-based view of the firm. In a review of the resource-based view of the firm, Mahoney and Pandian (1992) set out the link between talent as a resource and successful competitive strategies. The emphasis is on performance systems, performance management and control over individual activities, with the ultimate aim of creating a set of resources which give the firm a strategic advantage.

These polarized notions of what talent management is prompted us to study the unfolding of talent management strategy in the NHS since 1970 and to look at whether the current strategy is fit for purpose.

Methods

The case study described here was part of a project on talent management in the NHS funded by the NIHR SDO programme. We looked at documents which described, summarized or analysed the approach taken to talent management in the NHS. Our search was limited to publications between 1970 and 2011. However, these included previous analyses by others which had looked historically as far back as 1948. Our data sources were academic literature; policy documents; and

strategic and operational documents. We defined hard and soft talent management approaches in terms of the characteristics shown in table 1. Each document was read and re-read to gain familiarity with the data.

We piloted (but abandoned) a semi-quantitative approach in which we counted the number of times soft and hard terminology was used in a policy or strategy document. This proved invalid because such documents frequently included reference to what Truss *et al*. (see quotation above) has called a 'soft commitment model' (for example via statements such as 'we value our talented staff'), even in the absence of any other features of the soft talent management approach.

Findings

Description of dataset

Our original search identified some 20 academic papers and over 100 potentially relevant policy and operational documents. This dataset was reduced by scanning titles and abstracts for relevance. We selected 10 DH white papers for full thematic analysis.

Soft talent management in the early years of the NHS

The academic reviews in our dataset, along with the introductory sections of some later policy documents, provided useful historical background. As far back as 1948, it was recognized that the new NHS would require 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 the King's Fund) ran programmes to support the development of administrative, nursing and catering staff in the NHS. Its council minutes from 1955 confirm that the fund was developing schemes to produce 'well-trained administrators who would be competent to fill senior administrative posts in years to come' (Saunders, 2006).

A year later, details of this scheme were set out by the Ministry of Health. Saunders (2006) summarizes its goal to:

> *…provide for the selection and training for senior posts of the younger officers in the hospital service who are showing promise; 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.*

The first intake of 14 trainees to the scheme was in September 1956.

The 1980s: a shift in the logic of talent management

The emergence of talent management as a formal strategy 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'

Table 1. Defining characteristics of hard and soft talent management used in our analysis.

	Hard talent management	*Soft talent management*
Underpinning logic	Managerial: ensuring tight integration of talent management with HR policies, systems and activities with the firm's business strategy	Humanistic: generating commitment via development, communication, motivation and leadership. Treating talented employees as valued assets and a source of competitive advantage
Goal	To ensure that the organization's stock of talent is best matched to its business objectives.	To recruit, develop and manage talented people
Link between talent and business objectives	Explicit and direct	Implicit and indirect
Success defined in terms of	Generation of wealth/profit for the organization	Employees achieve their full potential. Organization achieves its goals (which may be wealth or public goods)
Talent depicted as	A (potentially scarce) resource, to be built up in the organization, moved around, deployed and monitored. Abstracted from the people who possess it	A source of creative energy. Synonymous with the people who posses it
Employees depicted as	(Passive) 'HR': possessors of talent; recipients of training or development; workers to be deployed in the pursuit of business goals	(Active) 'resourceful humans': agents who engage proactively with the organization's mission; capable of development, worthy of trust and collaboration

(Grint, 2000). 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 public sector ethos by supposedly superior private sector practice (Rhodes, 2005). This trend explains the expansion of HR departments and the HR function within public sector organizations.

In 1983, the national responsibility for the NHS management training scheme was transferred to the NHS Training Authority and it was renamed the 'national management training scheme'. This followed the Griffiths Report (DHSS, 1983), which introduced an explicit policy of adopting a more business-like approach to leadership and management in the NHS (with a view to increasing efficiency, reducing variation and reducing waste), including recruiting senior leaders from the private sector and making managers more visible and proactive.

Talent management in the 'new NHS'

The first health white paper of the 1997–2010 Labour government, *The New NHS: Modern, Dependable*, while ostensibly seeking to move away from the internal market introduced by the previous government, actually retained and extended many aspects of a 'market' orientation and also introduced significantly tighter central reporting and accountability structures (Macfarlane *et al*., 2011). As part of this new public management approach, increasing emphasis was put on tightening the link between workforce planning and people management. An infrastructure began to be built to operationalize this, which included but was not limited to the establishment of the NHS Modernization Agency (DH, 1999, 2000).

In 2000, a consultation document on the review of workforce planning was published: *A Health Service of All the Talents*. This summarized the response to a consultation on developing the NHS workforce, which was launched in April 2000. Interestingly, *A Health Service of All the Talents* does not mention the word 'talent' at all after the introduction (DH, 2000). Rather, its focus is on future workforce planning arrangements, which centre on new ways of working, which are listed as:

- Teamworking across professional and organizational boundaries.
- Flexible working to make the best use of the range of skills and knowledge which staff have.
- Streamlined workforce planning and development which stems from the needs of patients not of professionals.
- Maximizing the contribution of all staff to patient care, doing away with barriers which say only particular staff can provide particular types of care.
- Modernizing education and training to ensure that staff are equipped with the skills they need to work in a complex, changing NHS.
- Developing new, more flexible, careers for all staff.
- Expanding the workforce to meet future demands.

In 2002, the Department of Health (DH) published another white paper called *Liberating the Talents: Helping Primary Care Trusts and Nurses to Deliver the NHS Plan* (DH, 2002). This set out the changes to roles of front line staff, such as nurses and midwives, in the delivery of the NHS Plan. The central aim was to ensure that the input of these staff groups could be used to improving the health and health care of the population. Although the word 'talent' was included in the title, it did not describe any recognized talent management approach to achieve its aims. Rather, it focused on redefining roles and reorienting these more closely towards business objectives. Ford *et al*. (2010) agree with this, arguing that talent management in their study in one region of the NHS adopts a 'hard approach'.

A growing focus on 'leadership development'

The focus on talent management as a means of developing leadership in the NHS can be seen in various white papers and reports over the last decade. For example, in 2004 the NHS adopted a new approach to identifying and developing managers, with the establishment of a national talent management team whose aim was to 'identify and position high potential individuals to have a disproportionately positive impact on the organizational performance' (DH, 2004). This marked a significant shift in the discourse around talent management: talent was now seen as a 'strategic resource'. The document also stated: 'good leadership at every level is a significant factor in improving the quality of patient care and the health of the population', and proposed the establishment of an 'executive talent pipeline' which would identify, track, develop, position and retain critical leadership talent within the service.

In July 2005, the Leadership Centre and Modernization Agency were abolished and

the management training scheme, together with the two other national schemes (finance and human resources) transferred to the NHS Institute for Innovation and Improvement (NHSIII). The annual intake of management trainees was increased from 70 to 90 to reflect the growing demand from an expanding NHS. The scheme aimed 'to recruit graduates and comparably qualified individuals annually onto a two-year, full-time scheme…to develop the future leaders of the NHS' but it also incorporated an element of development based on the new NHS leadership qualities framework and top leaders' scheme (Saunders, 2006).

In 2008, a programme was set up to identify future leaders and active talent spotting was made a priority (Gander, 2008). The Darzi Review (DH, 2008b) also stressed the importance of leadership and 'unlocking' talent. National working groups on workforce and on leadership were set up, and a workforce strategy published (DH, 2008b). In 2010, a set of medical leadership competencies was published to guide the activities of clinical leaders, which mirrored a leadership qualities framework produced for non-clinicians in 2002.

In 2009 the DH published *Inspiring Leaders* (DH, 2009). According to the foreword by David Nicholson, the purpose of this guidance was to provide a best practice framework for the development of leadership across health care:

> *We have looked at evidence from across the globe…We will really struggle to deliver locally-driven services that are responsive to the needs of individual patients if our leadership and workforce are not representative of the communities we serve…I invite you to use [the guidance] and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.*

Tellingly, the emphasis was on developing and managing leadership as an abstract resource, rather than on leaders as resourceful individuals. The assurance process for talent management was based around a set of key performance indicators (KPIs) and covered: talent management strategy (vision); current performance (diagnosis); action plans to address key shortages (plans/closing gaps); leadership development programmes (pathways); joining with other development activities (links); and identifying potential problems with the talent management plans (barriers).

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 on strategic health authorities (SHAs) to take lead responsibility for talent and leadership management across the health care system (DH, 2007). It articulated the DH'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 DH to producing guidance for the NHS on talent and leadership planning. It stated that spotting more future leaders is one element of what good leadership is all about.

In recent years, talent management strategies have focused increasingly on building the stock of 'leadership' in the NHS. For example the Darzi Review (DH, 2008b) announced that a new standard in health care leadership; a 'leadership for quality certificate' would be introduced. The NHS started to support the 'top 1000' clinical and non-clinical leaders in the NHS and to provide them with resources for personal development, mentoring, and active career management. National working groups on workforce and on leadership were set up, and a workforce strategy focusing on these top 1000 was published (DH, 2008a). The NHS Leadership Council was made responsible for overseeing all matters of leadership across health care, with a particular focus on standards (including overseeing certification, the development of curricula, and quality assurance). The council can commission development programmes from the private sector.

This focus on 'top 1000' leaders was oriented mainly to filling chief executive and clinical director posts. Responsibility for this was seen to rest largely with local employers. SHA boards were required to ensure that a completed transformational leadership programme (TLP) was in place by the end of July 2009. Initially the prime focus was to be on aspiring chief executives and aspiring directors. However, in the longer term, it was anticipated that the five-year outcomes for SHAs would be that a 'systematic' approach would be in place, with increased leadership supply (including clinical leaders); and that leaders would reflect the workforce and the communities they serve (particularly black and minority ethnic staff, women and people with disabilities) (DH, 2009).

Talent management as a rational business process

In recent documents talent management is explicitly and directly linked to success and strategy. For example, according to the NHS London's plans for talent management (NHS London, 2009), the vision for talent and leadership for quality is a future in which:

> *…we are spoilt for choice (for example, there will be three suitable candidates short-listed for every vacant chief executive post) 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.*

Exploratory 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; and valuing diversity across the system (so that leadership represents the wider workforce) (DH, 2009).

DH guidance introduces the term 'diagnosis' to describe 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 (DH, 2009). 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 need to be aligned. Individuals need to be assessed not only on their current performance, but also against their potential and ambition. These data are presented in the form of an 'dashboard', which is calibrated as Red, Amber and Green. This shows the 'RAG status' demonstrating the ratio of actual (in other words, available potential chief executives) 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 (DH, 2009). So a Green rating would indicate that for every chief executive post advertised, three suitable (appointable) candidates are available on the short-list.

This centrally-determined measurement process then looks at four other areas:

- 'Spoilt for choice' looking at demand, supply and gaps for 'ready now' talent (0–1 year) and 'growing' (or ready soon: 1–3 years) talent for chief executives and directors.
- 'Encouraging more clinicians to become leaders'—an indication of the proportion of the 'ready now' talent pool for chief executives who are clinicians and doctors.
- 'Reflective of our communities'—an indication of the proportion of the 'ready now' talent pool who are from BME backgrounds, women, and have a disability.
- 'Transparent about what is required to progress and supportive of staff to get there' looks at how many managers have had an appraisal and personal development plan 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.

Interestingly, although being 'spoilt for choice' is a key theme of the guidance, nowhere is it clearly defined (DH, 2009).

Discussion

Our case study of the NHS has demonstrated a steady shift from soft to hard talent management from the mid 1950s to 2011. In particular, our analysis of the last five years suggests an acceleration of the logic and values of hard talent management, with the following key features:

- Talent is increasingly seen as an abstract, strategic resource for NHS organizations.
- The focus of talent management is narrowing on 'leadership', specifically on a select cohort of managers who will form a recruitment pool for chief executive and clinical director posts and whose development centres on the achievement of predefined competencies.
- The talent management process is increasingly rationalistic and bureaucratic—for example it operates by categorizing, classifying and quantifying the potential leadership pool and expressing knowledge about this stock of talent in centrally-held 'dashboards'.
- The talent management process is increasingly centralized, standardized and performance-managed, with the NHS requiring SHAs to put specific procedures in place and SHAs in turn placing expectations on local NHS organizations.
- Talent management is tightly linked to the pursuit of strategic goals both locally and

nationally.

Thus, talent management in the NHS has moved on significantly from the early days in which a group of management trainees were sent for staff development in a third sector organization. It now embraces a large-scale approach closely linked to workforce planning and centred on the creation and maintenance of talent pools, fed by talent management processes and procedures and oriented to ensuring adequate numbers of employees for executive-level posts (Kesler, 2002; Pascal, 2004). Talent has come to refer largely or exclusively to high-performing individuals or those with high potential talent. Employees are classified by performance level (for example top, competent, and bottom performers are denoted as 'A', 'B', and 'C' respectively). 'C' players are likely to have their contracts terminated (see Axelrod *et al.*, 2002).

While talent management in the NHS thus appears to mirror ever more closely with what is assumed to reflect that in successful private sector companies, some researchers have found diverse and inconsistent approaches to talent management in the private sector (Lewis and Heckman, 2006). Others have suggested that successful private sector companies, even when they espouse hard talent management, take a more nuanced approach which recognizes the limitations of over-standardized procedures and reductive metrics of progress. Conger and Fulmer, for example, propose a number of rules of thumb for successful talent management in employees with 'exceptional potential': focus on development; identify the 'linchpin positions' (jobs that are essential to the long-term health of the organization); keep things transparent and open; measure progress regularly; and be flexible (Conger and Fulmer, 2003).

Even if hard talent management (with appropriate caveats) is fit for purpose for private sector firms, the question remains whether such an approach—'the quantitative, calculative and business-strategic aspect' of managing the 'headcount resource' in a 'rational' way (Storey, 1992)—is the best approach for the NHS. Blue-chip companies construe a top-performing 'cream' as critical for organizational success, yet low-paid staff within the NHS can have a major impact on health outcomes and efficiency. For one thing, front-line patient care is increasingly delivered by staff with minimal training (for example health care assistants). For another, health care operates to a very different economic model to commerce (for example hospital acquired infections are transmitted as readily by someone outside the designated talent pool as by someone within it, and an outbreak of such an infection can kill patients and close wards).

There is, as yet, limited empirical evidence of the impact of a hard talent management policy on the performance of the NHS. Ford *et al.* (2010) studied talent management approaches in an NHS region in the north of England and found no consensus on what 'talent' is or how it should be managed. They expressed concern that the current NHS approach to talent management sits oddly with its public sector ethos. Arguably, however, hard talent management aligns well with the wider strategic shift away in the NHS from a 'cradle-to-grave welfare state' and towards an efficient, well-managed business which embraces innovation (DH, 2008a).

Hard talent management is tightly coupled to a strategic business case approach. Developing staff is worth doing only if it provides a competitive, strategic advantage. Given the growing focus on efficiency savings in the UK public sector, will talent management be focused on developing staff for the long term or for a short-term 'efficiency-focused' future?

The future of talent management in the NHS is at an interesting juncture. The coalition government has proposed a 'bottom up' approach to workforce planning (DH, 2010a). Their white paper on *Liberating the NHS* (DH, 2010b) regards health care providers as the engine of the new system and introduced two new leadership organizations called Health Education England (HEE) and the NHS Leadership Academy. Between them they will support health care providers in their workforce planning, education, training, leadership development and talent management. The suggestion from the DH is that these two bodies will be free from day-to-day political interference. Whether this marks a turning point in the NHS talent management policy away from the current highly-centralized, bureaucratic and 'top down' approach, only history will tell.

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