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The snakes and ladders of National Health Service management in England

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SUMMARY

This article explores managerial careers in the National Health Service (NHS) through the lens of talent management, particularly focusing on how managers view barriers (snakes) and facilitators (ladders) to career progression. There is a significant literature on enablers and barriers to career progression, but much of this focuses on specific groups such as black and minority ethnic and female workers, and there is relatively little material on the general workforce of the NHS. The research design is a mixed method quantitative (questionnaire) and qualitative (interview and focus group) approach consisting 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 level, and examines talent management in high-performing NHS organisations. Ladders are identified as follows: volunteering, secondment, networking, mentoring, academic qualifications, development, good role models/managers and appraisal/personal development plan. Snakes are identified as managing expectations; identity and cognitive diversity; location; sector; NHS toxic and favouritism culture; poor talent spotting; credentialism; exclusive approach to talent; and sustainability. It concludes that while previous conceptual and empirical work is fairly clear on any ladders, it is less clear on snakes. Copyright © 2013 John Wiley & Sons, Ltd.

KEY WORDS: talent management; National Health Service; England

INTRODUCTION

Recent commentators stress the importance of management and leadership in the English National Health Service (NHS) (Hartley and Bennington, 2010; King's Fund Commission, 2011, 2012; Martin and Learmonth, 2012; Mid Staffordshire NHS FT Inquiry, 2013).[1] Issues include the problems of recruiting chief executive officers (CEOs) and their short average tenures (HoggettBowers, 2009); a perceived or real toxicity in the wider system inhabited by CEOs; an environment described as a 'brutal', 'arbitrary', 'prone to favouritism' and intolerant of risk taking that is not successful; an insular club that exhibits a suspicion of outsiders and wields patronage

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[1]Since the political devolution in 1999, health policy in the four nations of Britain has taken divergent paths (see, e.g. Greer, 2004).

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(NHS Confederation, 2009); and leadership that does not reflect the community or workforce (NHS III, 2009).

This may be connected to wider literatures such as the 'psychological contract' (Conway and Briner, 2005) and leadership toxicity and 'snakes in suits' (Babick and Hare, 2007; Walton, 2007). There are many definitions of the psychological contract, but Conway and Briner (2005: 35) defined it as an employee's subjective understanding of the promissory-based reciprocal exchanges between himself or herself and the organisation. In return for effort, skills and knowledge, employees expect in return pay, promotion, training, feedback and respect. Research suggests that perceived breach is strongly related to job satisfaction, moderately related to organisational commitment and the intention to quit, and only weakly related to organisational citizenship behaviours, job performance and actual turnover (p. 75).

Walton (2007) considered if workplace dysfunction and leadership toxicity are normal—rather than abnormal—phenomena of modern organisational life. He wrote of dysfunctional executive behaviour, punitive and abusive working environments, and a seemingly relentless drive for employees to achieve more and more with fewer and fewer resources, which result in increasingly difficult and toxic working environments, with growing expressions of dissatisfaction by employees with the quality of the leadership they receive. He presented three 'lenses' that form the actor–context–external framework: first, viewing the behaviour of the executive(s) as actor; second, looking at the internal 'context' of the organisation (its internal culture and climate); and third, reviewing the external environment (the 'external' world) in which the organisation finds itself. Babick and Hare (2007) went further, arguing that psychopaths do work in modern organisations. They are often successful by most standard measures of career success, and their destructive personality characteristics are invisible to most of the people with whom they interact. They are able to circumvent and sometimes hijack succession planning and performance management systems in order to give legitimacy to their behaviours. They take advantage of communication weaknesses, organisational systems and processes, interpersonal conflicts, and general stressors that plague all companies. They abuse co-workers and, by lowering morale and stirring up conflict, the company itself. In short, through their games, these snakes in suits manipulate others.

This article explores managerial careers in the NHS through the lens of talent management (TM), particularly focusing on how managers view the 'snakes and ladders' of career progression. The (succeeding) literature broadly uses the terms barriers and facilitators, but as some respondents considered career progression as a 'game' that those wishing to progress were forced to play, the terms of snakes and ladders are used instead. There is a significant literature on enablers and barriers to career progression, but much of this focuses on specific groups such as black and minority ethnic (BME) and female workers (e.g. Beattie *et al*., 2006; Ogden *et al*., 2006; McNamara *et al*., 2009; Ashmead *et al*., 2010), and there is relatively little material on the general workforce of the NHS, which is the largest employer in the UK. There is some work on 'inclusive leadership' whether in terms of identity diversity (e.g. Smith, 2008; NHS III, 2009) or clinical or medical leadership (Lane, 2000; Ham *et al*., 2011) that focuses on the barriers to progression of particular groups.

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The conceptual contribution of the study brings together the TM and careers literature, and stresses some problematic assumptions. The first assumption is an exclusive approach that focuses on ‘A players’ or ‘A positions’ (Ford and Harding, 2010). The second assumption is based on ‘objective’ organisational careers. Moreover, according to the Chartered Institute of Personnel Development (CIPD) (2010), research on TM programmes usually focuses on the employer’s perspective, with seemingly few focused on the employee perspective. It claims that their report therefore offers a fresh viewpoint and a new way of evaluating TM activities.

MANAGING CAREERS

Arnold and Cohen (2008) wrote that within the last decade, there has been a growing consensus about the demise of the ‘traditional’, bureaucratic career with its implicit sense of advancement from humble beginnings to more senior positions. A number of writers have at times used notions of ‘protean’ and ‘boundaryless’ careers synonymously, as a shorthand to connote careers that do not conform to bureaucratic norms; there appear to be different stress issues. The boundaryless career focuses on the weakening of people’s ties with organisations in the construction and enactment of their career. For example, the ‘Gateway’ scheme in the NHS is designed to encourage entry from experienced managers outside the NHS (Powell *et al*., 2012).

Whereas the boundaryless career metaphor is used to describe both physical and psychological dimensions of career, the protean career focuses on the latter and specifically on the achievement of subjective career success through self-directed vocational behaviour. It is broadly used to describe careers in which the individual, not the organisation, is in charge, the core values are freedom and growth, and the main success criteria are subjective (psychological) versus objective (position, salary). ‘Intelligent careers’ suggest the elements necessary for effective career management on the individual side, which includes the following: ‘know why’ (values, attitudes, internal needs, identity and life style); ‘know how’ (career competencies: skills, expertise, capabilities; and tacit and explicit knowledge); and ‘know whom’ (networking, relationships and how to find the right people) (Arthur *et al*., 1995). To these, Jones and DeFillippi (1996) added the ‘know what’ (opportunities, threats, and requirements), ‘know where’ (entering, training and advancing) and ‘know when’ (timing of choices and activities). The criteria of objective success include salary, rate of salary growth, hierarchical level attained in an organisation, proximity to CEO and number/rate of promotions, whereas the criteria of subjective success include career satisfaction, life satisfaction, job satisfaction and beliefs/perceptions about one’s employability. However, like most broad distinctions, the one between objective and subjective career success is less clear cut than it might at first seem, but evidence shows that career progression means different things to different people and that what respondents define as a ‘successful career’ is strongly related to their own ambitions and life circumstances.

MANAGING TALENT

Lewis and Heckman (2006: 139) pointed to ‘a disturbing lack of clarity regarding the definition, scope and overall goals of talent management’. However, a working

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definition of TM as given by the CIPD (2008) involves '… the systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation.' (i.e. A players).

Lewis and Heckman (2006) identified three key streams of thought around the concept of TM. The first stream consists of those who merely substitute the label TM for human resource management. Studies in this tradition often limit their focus to particular HR practices such as recruitment, leadership development and succession planning. The second stream stresses the development of talent pools, which typically build on earlier research in the manpower planning or succession planning literatures. The third stream focuses on the management of talented people, variously termed 'A performers' 'stars' or 'topgraders'. Collings and Mellahi (2009) added an emerging fourth stream that emphasises the identification of key positions (rather than talented individuals *per se*), which have the potential to differentially impact the competitive advantage of the firm. Iles *et al*. (2010) linked these definitions with a 'exclusive/inclusive' differentiation to present four main perspectives on TM: 'exclusive-people', 'exclusive-positions', 'inclusive-people' and 'inclusive-positions' (social capital).

Although TM entered the NHS in 2004, there is a long history of 'managing talent' (mt) initiatives, which have been discussed in many documents and have been the responsibility of a long list of changing national and regional organisations (e.g. Saunders, 2006; Powell *et al*., 2012). For example, the 1960s and 1970s saw an 'mt' initiative of 'Planned Movement' organised by Regional Staff Officers and Regional Staff Committees.[2] In 2004, the NHS adopted a new approach to identifying and developing managers (DH, 2004). In January 2009, the Department of Health published its 'guidance for NHS talent and leadership plans' (DH, 2009). This required strategic health authorities (SHAs) to produce talent and leadership plans by July 2009. The importance of leadership was stressed by the Darzi Report (DH, 2008) and the National Leadership Council. However, almost as soon as TM was seen as an organisational imperative, the NHS entered a cold climate with a 'double whammy' of the need to make management savings and organisational change. The Coalition government of 2010 outlined plans to abolish primary care trusts, SHAs and the NHS Institute for Innovation and Improvement. The National Leadership Council has now changed into a new Leadership Academy. In August 2011, the government reported the summary of consultation to its workforce plans (DH, 2011), which stressed that development was the responsibility of employing organisations; a new body termed Health Education England should have responsibilities for the leadership development framework for managers as well as clinicians, and that leadership would be embedded into all levels of training and development, which must be coupled with good staff appraisals and continuing professional development.

ENABLERS AND BARRIERS IN CAREER PROGRESSION

Some recent studies focus on enablers and barriers. For example, CIPD (2010) reported a 2010 survey of about 300 responses from public and private organisations, including

[2]There are few easily accessible published available sources on these initiatives. I am grateful to the referee for this point.

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two NHS SHAs. It stressed coaching, mentoring and networking above the more formal development opportunities offered by a TM programme. A common cause for complaint was the perceived lack of transparency around the selection process, and respondents stressed that any perceived element of 'cronyism' would naturally lead to frustration among both those selected and those not selected. There were also comments about the consistency of the selection process, and for any organisation pursuing selective TM strategies, there were concerns over the impact that this may have on those excluded from programmes.

A number of studies (Beattie *et al*., 2006; Ogden *et al*., 2006; McNamara *et al*., 2009; Ashmead *et al*., 2010) examine enablers and barriers (or snakes and ladders) for specific groups (Table 1).

ENABLERS AND BARRIERS IN HEALTHCARE MANAGEMENT CAREER PROGRESSION

Fahey and Myrtle (2001) examined the job and career changes of healthcare executives and managers working in different segments of the healthcare industry in the western USA. They identify four different executive and management career patterns: multiple career changes (most common); a 'traditional' career in which one did not seek a career change; a single career change; and movement back and forth between two different segments of the healthcare industry. They note that one surprising finding of this research was the lack of association with gender and career paths. However, they did not offer a critical analysis of why managers' careers took the turns they did (Macfarlane *et al*., 2011).

In a study in the USA by Moats Kennedy (1996: 11), respondents said they judged career success

> '*by the degree of balance in their lives, their ability to adjust to changes in the field, the degree of satisfaction they derive from their work, and the effect they have on their communities*'.

In other words, according to this study, success may not depend on achieving a particular position (such as CEO), or a particular grade of salary. Moran *et al*. (2011) explored career progression for nurse executives in Australia, particularly focusing on the personal, work-related and professional factors, which influence progression.

Macfarlane *et al*. (2011) interviewed 20 NHS senior managers, of whom 12 had been CEO. One of their themes was how career paths unfolded. Almost all had worked in different NHS organisations, especially early on, and saw a 'good' career pathway as accumulating a broad range of experience and practical wisdom across the heterogeneous organisations that made up the NHS. Some pointed to the 'golden pathway' that referred to a formal leadership development programme, which targeted potential leaders and gave them the support, education and experience to take on more senior roles (but see Davies and Rosser (1986) for the gendered nature of the golden pathway). Many identified colleagues who had played the role of mentor or guide in arranging this varied experience.

Barber (2010) focused on the CEO in NHS Yorkshire and the Humber in 2009, with a survey, interviews and stories. She presented five themes relating to being a

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Table 1. Snakes and ladders in career progression and talent management studies

Dimension	TM	Careers	General studies	Healthcare studies
Ladder				
Volunteering		Know what; know whom		Barber (2010)
Secondment		Know what; know whom		Barber (2010)
Mentoring		Know what; know whom	Ashmead *et al*. (2010); CIPD (2010)	Barber (2010); Macfarlane *et al*. (2011); Moran *et al*. (2011)
Networking		Know what; know whom	Ashmead *et al*. (2010); Beattie *et al*. (2006); CIPD (2010); Ogden *et al*. (2006)	Barber (2010)
Academic qualifications		Know how	McNamara *et al*. (2009)	Moran *et al*. (2011)
In service training and development	TLP	Know how	Ashmead *et al*. (2010); CIPD (2010); McNamara *et al*. (2009); Ogden *et al*. (2006)	Lane (2000)
Good line manager		Know whom	Ashmead *et al*. (2010); Beattie *et al*. (2006); McNamara *et al*. (2009)	
Good role model		Know whom		
Appraisal/ PDP	TLP	Know whom		
Snakes				
Managing expectations				
Identity diversity	TLP	Know whom; know what; know why	Ashmead *et al*. (2010); McNamara *et al*. (2009); Ogden *et al*. (2006)	NHS III (2009)
Cognitive diversity		Know whom; know what; know why		
Location		Know where; know whom; know when		
Sector		Know where; know whom; know when		
NHS ‘favouritism’ culture		Know whom		NHS Confederation (2009)
NHS ‘blame’ culture		Know why (values)		NHS Confederation (2009)

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Table 1. (Continued)

Dimension	TM	Careers	General studies	Healthcare studies
Poor talent spotting		Know whom		
Credentialism		Know what		
Exclusive approach		Know why (values)		Ford and Harding, (2010)
Sustainability		Know when		

TM, talent management; TLP, talent and leadership plans; PDP, personal development plan.

CE, while the sixth concerns ‘how to become’ one, which included diverse job experiences; valuable support structures (e.g. secondments, coaching and mentoring, and personal networks); visibility (maximising access to a range of opportunities and being proactive); formal and informal opportunities (e.g. work shadowing, sabbaticals, volunteering, formal development activities such as action learning sets); and critical decisions (being ‘role ready’ or being spotted by other senior managers).

Ham *et al*. (2011) pointed to the ‘many and varied’ career paths of medically qualified CEO in Britain. The training and development accessed by medical leaders en route to becoming CEO was highly variable, and in most cases, interviewees had to seek advice from more senior colleagues and were reliant on these colleagues and others who acted as coaches and mentors. Most interviewees emphasised the value they placed on learning on the job rather than taking part in formal programmes, comparing learning to be a leader with medical training and its emphasis on ‘see one, do one and teach one’. They also stressed the need to tackle barriers in the management culture in the NHS.

In short, although there is some material on the barriers and enablers for particular groups and in particular countries, there is little knowledge of snakes and ladders for the NHS managerial workforce as a whole.

RESEARCH METHODS

The research design is a mixed method quantitative (questionnaire) and qualitative (interview and 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 SHA level, and examines TM in high-performing NHS organisations. Fuller details are available in the project report (Powell *et al*., 2012), but in brief, the research was conducted in six separate stages:

(i) Literature review: structured search using a number of terms such as ‘TM’ from a number of databases and documentary analysis of Department of Health and SHA documents.
(ii) Two ‘heterogeneous’ (age, gender, organisation and professional backgrounds) sets of focus group of managers in late 2009 (13 managers) and late 2010 (11 managers).

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(iii) Qualitative interviews with those responsible for TM at national and SHA levels (22 interviews to cover central and SHA perspectives, conducted in December 2009/January 2010, with two in June 2010).
(iv) Qualitative interviews with four cohorts of managers from a variety of socio-demographic and education backgrounds in a variety of roles in different organisations (42 interviews).
(v) Questionnaire survey focusing on basic career histories and experiences of TM and mt provided the 'breadth' component to 'depth' of cohort interviews. The main problem was the lack of a single sampling frame of NHS managers (lie the medical register), and so a variety of databases were used, resulting in 556 usable 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, which were roughly representative of age, gender and organisational type. In addition to quantitative data, free text responses were also collected.
(vi) Exploration of NHS staff survey and qualitative (interview) examination of TM in three high-performing trusts (HPT): a non-foundation trust acute provider trust (APT), a mental health trust (MHT) and ambulance trust (AT). Interviews were conducted with the TM lead and other staff at each trust. Six interviews were completed at our ATs and MHTs and seven at our APT.

Silverman's (2006) suggestions were followed to enhance the overall reliability of qualitative research: thorough pre-testing of interview schedules by comparing how at least two researchers analyse the same data; conducting the interviews as far as possible under standard requirements; and presenting 'low-inference descriptors', which means 'recording observations in terms that are as concrete as possible, including verbatim accounts of what people say' (Seale, 1999: 148) and tape recording all face-to-face interviews, carefully transcribing these tapes and presenting long extracts of data in the research report (Silverman, 2006: 287). Positive influences on career progression were coded as ladders, while negative influences on career progression were coded as snakes.

LADDERS

There are a number of ways of climbing ladders.

Volunteering

Cohort respondents stressed that 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*.' (C23)

Similarly, some stressed that you had to push or 'make your own luck' in the manner of the anecdote ascribed to golfer Gary Player ('the more I practice, the luckier I am'):

'*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)

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Secondment

Focus group discussions about secondments and 'acting up' were very positive and were clearly noted as one effective way to grow in one's career. Similarly, for cohort respondents:

'*[Acting up at CEO] so I knew that I could do the job and that I enjoyed it*.' (C11)

Survey respondents also recognised the value of 'stretch assignments', although one stated that:

'*I was told that if I wanted a secondment, not to come back!*'

Networking

For cohort respondents, 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*.' (C32).

Mentoring

Many cohort respondents 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'. Coaching was seen as particularly important as times of reorganisation and for new CEOs. Many survey respondents 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.

'*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*.'

Academic qualifications

The survey suggested that the NHS has a well-qualified managerial workforce. Some 72% of respondents had a degree, with 55% having a higher degree, 43% having National Vocational Qualifications and other vocational qualifications. Moreover, staff were keen to continue to study (see succeeding discussion).

Development

Just over a third (36%) of survey respondents were aware of the current TM initiative in the NHS, although some who were 'not aware' had attended SHA courses such as aspiring directors (AD) and 'aspiring chief executive' (ACE). Some 84% of survey

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respondents 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 the graduate Management Training Scheme (11%).

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 personal development plans (PDPs) arising from appraisals (4%) (see succeeding discussion). 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 value to CV:

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

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

'*Credibility with others through having a formal qualification*.'

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 or organisational support (22%). The remaining 19% broadly represented 'choice':

'*Intending to take early retirement within 2 years*.'

Some 170 respondents (37%) reported problems either obtaining training or problems on training. Of these, some 104 respondents (about 61%) had problems obtaining training, with the main issues being time (52% of the 104), funding (41%), workload (40%) and line manager or organisational support (29%). Some 82 respondents (48% of the 170) reported problems during their training, with the main issues being time (71%), workload (56%), line manager or organisational support (20%) and funding (17%).

'*Action Learning Sets 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*.'

Most of our HPT 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)

'*… five day residential management development module in 1990s was 'brilliant experience'; took me to a different level of management*.' (APT 5)

Good role models/managers

In drawing out the career maps, I asked focus group members to think about enablers and barriers to progression. Several people commented on supportive

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managers who had helped them throughout their career. Similarly, many cohort respondents pointed 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.

Appraisal/personal development programme

The issue of appraisal/PDP indicates that what should be a 'ladder' can often be a 'snake' in that the appraisal process was broadly viewed in negative terms in both quantitative and qualitative senses. Some cohort respondents 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*.' (C21)

'*My experience of the NHS is that there isn't really one [appraisal process]*.' (C27)

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*.' (C35)

'*Appraisals have got better over past 5 or 6 years. More detailed and more honest*.' (C18)

'*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 Human Resource Director banging the drum*.' (C32)

However, the majority view was that where appraisals did take place, their value was often seen as limited, but a 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*.' (C25)

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*.' (C21)

'*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 fees a bit like ticking boxes. Often a pretty superficial conversation*.' (C16)

Informants from the HPT stressed the importance of appraisals and the links with PDP. However, it was felt that the appraisal process had some shortcomings, particularly being seen as a 'tick box' exercise:

'*Appraisal—quarterly reviews and yearly action plan. MSc was borne out of action plan*.' (AT 4).

As one SHA respondent put it,

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‘*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*”.’ (S5)

SNAKES

In addition to the ladders, there are a number of snakes.

Managing expectations

SHA respondents pointed out that there was often a lack of consistency between and within organisations, so that different people had different views of ‘talent’. In some cases, talented people did not put themselves forward or were not spotted. In other cases, there was an over-optimistic view of talent. Moreover, the identification of individuals identified as ‘talented’, including the top leaders programme, 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 that historically operated in Britain (see also ‘Location’):

‘*Some person wants to be a Director and you kind of think “well, dream on really” [laughter] … I advertise 8 Directorships, most senior operational managers and God I could weep at what we get…Or you see people who seem to have no aspirations and you think “well why not, they’re brilliant*”.’ (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…*’ (G)

‘*In recent 3 or 4 CEO 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 CEO job and what’s been deemed to be actually somebody for CEO.*’ (7)

Identity diversity

The documentary analysis suggests that most SHAs recognise that BME staff in existing senior management and talent pipelines are not representative of the workforce or community. For example, 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’ (NHS Yorkshire and the Humber, 2009: 10). The focus group 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.*’

This view was also expressed by a cohort respondent:

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'*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*.' (C4)

There was broad consensus among the SHA respondents that NHS leadership was not representative of workforces or communities:

'*[The first AD course] was by nomination by CEO. 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*.' (S11)

'*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)

In the cohort interviews, 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*.' (C21)

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

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

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

'*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).

Cognitive diversity

Focus group 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 (2007) considered that 'cognitive diversity' (thinking differently) is more useful than 'identity diversity' (gender and 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*.'

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Similarly, one cohort respondent suggested that they were not in the 'in crowd' (see also 'NHS favouritism culture'):

'*Just feeling that I was not on the list of people who were allowed to get [category] Director jobs in the NHS… Conformity is more important than talent*.' (C9)

Location

The documentary analysis suggested that there is some variation in 'Spoiled for Choice' (SFC) data for the SHAs that gave comparable data. Some SHAs such as NHS Midlands (2009), NHS North West (2009) and NHS Yorkshire and the Humber (2009) claim to be SFC for most or all of the categories. Indeed, NHS Yorkshire and the Humber (2009: 13) stated that low turnover of CEO 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).

Strategic health authority respondents recognised that mobility and turnover varied between and within areas. In particular, SHAs or parts of SHAs close to London can 'haemorrhage talent'. For some regions:

'*Low turnover for CEO. 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*.' (S1)

'*In many areas we are SFC, so we decided not to run a third cohort for AD*.' (S6)

Sector

Some cohort respondents 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 (as in the 'golden route'), 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*.' (C6)

'*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*.' (C14)

'*People warned that leaving acute for mental health could be the death of my career*.' (C22)

NHS favouritism culture

Fairness and transparency were regarded as major concerns: As one focus group participant put it:

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

Similar terms were used by some SHA respondents:

'*Trying to rid of the old boy's network and tapping him on the shoulder*.' (S5)

'*We are talking about patronage. If your face fits you get everything and if your face doesn't you get nothing*.' (A)

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Some survey respondents had more fundamental criticisms of principle or were cynical that TM 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*.'

'*Glass ceilings are alive and well in the NHS*.'

One cohort respondent stated that:

'*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*.' (C29)

Similarly, one HPT respondent stated that they had:

'*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)

NHS toxic culture

In addition to the perceived favouritism culture, some respondents considered that the NHS had a 'toxic' culture (NHS Confederation, 2009; cf. Babick and Hare, 2007; Walton, 2007). Some focus group participants stated that:

'*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*.'

Similarly, according to a few cohort respondents:

'*Line manager was pretty awful, a bully, so I decided that enough was enough*.' (C38)

'*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*.' (C40)

Poor talent spotting

Some focus group participants expressed some disbelief that any system can be objective, being necessarily variable and reliant on individual 'talent spotting':

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

Similarly, for some SHA respondents:

'*Identifying talented managers is the "million dollar question".. Initially, ACE participants were self identified, but checked by a panel of CEO, and they did not have a common understanding of what talent was. Newly appointed CEO were looking for skills, while experienced CEO were much more looking at potential*.' (S1)

'*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*.' (S1)

'*Identification of talent is subjective rather than objective at the moment*.' (S4)

'*Simply do not think we have the rigour. It still relies quite a bit more than it should on individual spotting*.' (S11)

'*Need more rigorous and transparent process*.' (S7)

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 talent database*.' (S3)

'*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*.' (S5)

'*We need a minimum dataset that it transferable so that my talent means the same to you in your region.*.' (S8)

Credentialism

Whereas academic qualifications were viewed as a ladder (as discussed earlier), some felt that lack of formal qualifications such not be regarded as a barrier. This appears to fit with NHS Scotland's practice-based approach to leadership development (Edmonstone, 2011). A 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*.'

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*.'

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

Some cohort respondents felt that 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*.' (C25)

'*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*.' (C29)

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*.' (C33)

Exclusive approach to talent

There was some disquiet in the focus groups at the use of the term 'talent', with unfortunate resonances of ideas about celebrity and 'rising stars', dividing people into 'winners' and 'losers', thoughts that TM may only apply at certain senior levels, and focusing on personality-based explanations such as 'intelligence' wrenched from the wider social context. Again, this appears to contrast with a more inclusive approach to talent in NHS Scotland (Edmonstone, 2011).

'*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?*'

Similarly, for SHA respondents:

'*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).

Some survey respondents also considered that TM:

'*Can become too targeted at senior and very senior managers*.'

'*Could be exclusive … if not handled right*.'

'*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*.'

All three of our HPT organisations appeared to take an inclusive approach rather than an exclusive 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)

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'*I strongly believe that TM should not stop at people who are at AD level*.' (APT 2)

'*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.*.' (MHT 1)

Sustainability (including reorganisation)

Survey respondents were concerned that the recent Coalition government's reorganisation resulting from the 'Equity and Excellence' White Paper (DH, 2010) could undermine the sustainability of TM:

'*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*.'

Many cohort respondents 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 Health Authorities being abolished*.' (C1)

'*[Reorganisations did] not get rid of those who should go but those who are easier*.' (C32)

DISCUSSION

The table compares the factors from the current study with the literature on careers, TM, and on barriers and enablers. The careers criteria (know why; how; whom; what and when) map onto the factors fairly well, but the TM factors from the NHS talent and leadership plans appear to have less clear relationship. Whereas there is some broad agreement on some of the ladders/enablers from previous empirical studies, there is less agreement on the snakes/barriers. To some extent, this reflects differences between the workforce as a whole in the NHS and the focus on specific groups in other sectors and places. However, it does highlight a set of factors, particularly the 'snakes', which deserve more focus in NHS careers.

CONCLUSION

This study has explored some of the snakes and ladders in NHS managerial careers. It has explored a relatively neglected area of NHS managerial careers as a whole, rather than on particular groups. It shows that although previous conceptual and empirical work is fairly clear on any ladders, it is less clear on snakes. While the Francis Report (Mid Staffordshire FT Inquiry, 2013) focuses on the implications

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of NHS culture for patients, it is clear that it may also have similar implications for managerial careers in the shape of a perceived club on the basis of patronage, toxicity in the wider system and perceived breaches of the psychological contract, which has negative implications for staff attitudes and behaviours. There is little available systematic evidence that would permit comparisons over time, between the NHS and other organisations in Britain or with other healthcare systems. However, Walton (2007) considered that a significant increase in toxic behaviour and internal instability is more likely to occur and be tolerated when all three of his dimensions are sufficiently aligned: a psychological predisposition for errant working; an internal context that permits or encourages errant behaviour to occur and be rewarded, and significant external circumstances that provide the wider context, cover and excuse for toxic behaviour to take hold. On the basis of the empirical evidence in this paper, it can be at least hypothesised that there are some grounds for predicting sufficient alignment for an NHS ‘perfect storm’.

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