PAUL TURNER

TALENT MANAGEMENT IN HEALTHCARE

Exploring How the World's Health Service Organisations Attract, Manage and Develop Talent

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This book is dedicated to the talented people who work in healthcare throughout the world and have such a positive effect on all of our lives.

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No Health Service Without a Health Workforce

Human Resources Are Critical to Universal Health Coverage

It is a universal truth that there will be no health service without a health workforce (World Health Organization [WHO] 2014).

But in many geographies, the demand for health exceeds the supply of people who can provide it. This is in spite of a workforce of over 40 million and spending on healthcare worldwide of US$7.2 trillion, equating to 10.6% of global gross domestic product (Deloitte 2015).

A convergence of forces has had a dramatic effect on the balance of demand and supply. Amongst these are social and demographic change (Girasek et al. 2016); the consequences of ageing; the growing risk of non-communicable diseases and a broader definition of what is understood by the meaning of health, which now refers to the totality of human welfare, extending beyond a 'narrow' biomedical view (Salomon et al. 2003). In its contemporary form, health is a 'state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity' (WHO 2016) and satisfies the demands of a life commensurate with age, culture, and personal responsibility (Bircher 2005). It relates to everyday

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life, not just the object of living, and is a fundamental human right that is recognised in the Universal Declaration of Human Rights.

The context for health services worldwide is therefore set by these factors together with pressures on health budgets and a growing demand for a return on investment in health. The fact that health services are now seen as vital to national economies contributing to development, growth and stability adds further weight to their importance. Undoubtedly, continuing progress in human longevity (Gratton and Scott 2016) and a broader definition will necessitate not only step changes in technology for health but a significant increase in the number of talented health professionals.

To address the human resource challenges, the WHO, the Global Health Workforce Alliance and others have called for macro, interconnected efforts and innovative approaches to workforce planning and management (WHO 2013): broadening the recruitment pool, creating targets for producing larger numbers of health workers, and offering greater career opportunities and flexibility in health systems (Maeda et al. 2014: 42; Girasek et al. 2016).

Healthcare HR Is at a Crossroads

Such targets are also framed in the context of affordability and sustainability compounded by change in the sector which is not happening in small incremental steps but in quantum leaps impacting on a wide range of organisational drivers from technology infrastructure to finance and business processes (Kabene 2010; Hopper 2015). In addition, since quality care begins with quality people, there is a dynamic to make sure that human resources decisions support both immediate organisational goals and the long-term aims of staffing with highly qualified individuals (Fried and Fottler 2008; Pynes and Lombardi 2011). On the one hand, this means training, education and development in each of the professional specialisms such as doctors, nurses or allied health professionals (Sambrook and Stewart 2007); on the other, it means strategic management of human resources as a whole to ensure that qualified, motivated personnel are available to staff the full portfolio of health units (Hernandez and O'Connor 2010). In all cases, health service human resources are key determinants of health service performance (Dubois et al. 2005).

Solutions to health challenges are categorised under the heading of 'human resources for health' and take place in a cycle of macro geopolitical and geosocial initiatives influenced by labour market economics and principles of ethics and morality (in transnational recruitment, for example). At a micro level, the challenge facing regional and local health sector organisations is how to integrate laudable global aspirations into their own specific objectives and operationalise them in day-to-day practice. The role of the health organisation human resource professional is often more complex than that of counterparts in other sectors. It is a role that includes common goals across the sector but often competing priorities within it (Deloitte 2015). Talent and talent management feature heavily in their sphere of interest.

Reframing the Concept of Health Increases the Demand for Health Sector Talent

Health workforce shortages are forecast to be significant—up to 15 million workers (Liu et al. 2016)—caused by not only demand-side issues as outlined above but supply-side ones since not enough people are entering the health professions. Regional imbalances and the migration of healthcare workers exacerbate the problem. For example, whilst over time the number of doctors per 1000 population is expected to remain virtually the same, the unequal distribution of health workers means that there will be large regional differences. The USA had 3.3 doctors per 1000 population in 2013—but still faces challenges in renewing and refreshing the clinical workforce—whilst countries in Africa and South East Asia have struggled to recruit and retain enough skilled medical staff to come anywhere near these ratios (Deloitte 2015). Furthermore, the numbers don't reflect demand and supply, as exemplified by the position in Sub-Saharan Africa, in which the disease burden is not matched by a commensurate proportion of health workers (Celletti et al. 2011).

The need to increase the numbers in the health profession has focused on low- and middle-income countries on the one hand, where it is a critical issue and where a shallow pool of those qualified to meet the demand for healthcare and the movement of healthcare workers from countries with scarce resource to areas of resource abundance 'presents a complex set of decisions and relationships that affect the development

of international health care systems' (Karan and DeUgarte 2016: 665; Maeda et al. 2014; Maurer 2015: 1). But, on the other hand, there is the challenge in high-income countries to recruit enough people to train for key health sector roles in the face of an increase in the demand for healthcare (Maeda et al. 2014; Maurer 2015: 1). The Association of American Medical Colleges, for example, has noted that under every scenario, the USA will face a shortage of physicians over the next decade (Association of American Medical Colleges 2016). The attraction, management, development and retention of talent into health are therefore not confined to one region or country. Instead, they are worldwide issues. A shortage of healthcare workers in Africa on the one hand and healthcare workers in China on the other; a 'silver tsunami' caused by retiring baby-boomer nursing workforce in the USA on the one hand (Moore 2015) to an undersupply of general practitioners and medical specialists in the UK on the other. Talent shortages in health are ubiquitous.

These factors have a significant effect on what might be termed point-of-care organisations and mean that the criticality of effective talent management has rarely been as important to success as it is today, nor more challenging. In addition, internal forces such as those caused by workforce demographics have reshaped health organisations, whilst global mobility, multi-generational and more diverse, empowered employees have changed their character. Traditional skills remain in demand, but new ones emerge for both clinical and technical or managerial roles. Success in this area therefore requires that organisations have a focus on more than just the numbers of talented employees. Instead, human resources and talent management will require insights into 'competencies, quality, motivation and performance' (WHO 2013: ix).

Talent Management in Health Takes Place in a Complex, Contested Economic Environment

Many of the factors that influence health, and the quality and quantity of the health workforce, transcend any one nation or organisation, which means that effective talent management is becoming a supranational and national

priority 'bound up in a complex and contested political economy, where the place, role, skills, aptitudes and mobility of health workers are central to health delivery, access, inequality, utilisation and outcomes' (Connell and Walton-Roberts 2016: 168). There is recognition of the important role of human resources for health in national priorities and international goals (WHO 2013: 2). But there is also recognition that health sector organisations, such as those at the community, hospital or health unit level, will need an equally strong focus on human resources and talent management. The observation that 'health care delivery cries out for a strategy, given the stakes, the scale and the sheer complexity of the task' (Porter and Teisberg 2006: 151) could apply equally to both international and local health organisations.

The unique context of health means that talent management is framed not only by the demographic and economic forces that pertain to other sectors but by ethical and moral issues such as those in recruitment that potentially pit south against north, nation against nation, and organisation against organisation in the quest to meet the increasing demand for health sector talent. The relatively free movement of health workers, whilst providing benefits for some countries, has also brought in its wake regional imbalances. Organisational talent strategies have this consideration in addition to the other factors.

Investing in the Health Workforce Can Create Economic Growth

Balancing global initiatives against local circumstances is therefore one of the stand-out features of talent management in the health sector.

How organisations define talent and talent management and how they establish talent strategies that are the best fit for their own contexts will be covered in detail in later chapters. But as a general statement, talent management includes, inter alia, the attraction, recruitment, management, retention and development of a broad range of clinical, technical and managerial health professionals.

The strength of interest has come about because there is a belief that 'the development of employment in the health and social sector is not only an imperative of international public health. It constitutes a major

economic and social opportunity to promote inclusive economic growth and creation of decent jobs, especially for women and youth' (Commission on Health Employment and Economic Growth 2016: 2). On this basis, investing in health will have dividends beyond the sector (Horton 2016). These are amongst the reasons that the United Nations Secretary-General announced the appointment of a Commission on Health Employment and Economic Growth in 2016, co-chaired by the presidents of France and South Africa. The terms of reference for the commission include commitments to the opportunity for individuals to receive training in their country of origin and the development of teaching capacities in low-income countries. In addition the right to freedom of movement in an environment where skills are acquired and developed as a result of the exchange and circulation of knowledge; and the need to improve supply and demand in national, regional and global labour markets are also referenced. And finally other issues include to anticipate migration flows, so as not to discourage investment in the health workforce in low- and middle-income countries, and to break the circle of loss of expertise (Commission on Health Employment and Economic Growth 2016: 2).

A significant consideration for this commission, and indeed all health sector organisations facing challenges in their human resources development, is to take account of a rapidly changing health and social care landscape (British Medical Association 2016) and ensure that responses are situationally relevant.

Talent Management Takes Place at All Levels

The above forces have an impact on global health organisations with policy and stewardship responsibilities; national organisations, including government Ministries or Departments of Health; and health provision organisations such as hospitals or those providing community health. As a result, the volume of research and practice output on the phenomena and their impact on organisations are enormous. Therefore, to provide focus, this book will concentrate mostly on the level of the point-of-care organisation or unit and groups of such organisations or units.

Within this, the book will focus on key areas of talent and talent management, including how they are defined; the specific role that talent has

in the achievement of organisational objectives through activities such as learning, training and development; and talent engagement and retention. This is itself the subject of some complexity. Sparrow and Makram (2015), in detailing the various philosophies about talent management that have evolved over the past two decades and beyond, put forward the view that they should not be seen as competing or alternative approaches, because they 'reflect different and alternative dimensions of a more strategic approach to talent management. Each philosophy makes different contributions to the potential study of the value of talent management' (Sparrow and Makram 2015: 254). They argue against over-reliance on meta-theories in favour of augmenting the human capital approach to talent with insights from other disciplines such as general management. Following these themes and including organisational strategy, the particular interfaces between talent and organisational dynamics will be explored as shown in Fig. 1.1.

There is an abundance of evidence from which to draw insights on the subject of talent management in health.

In fact, it is difficult to identify an area that has been subject to so much scrutiny, with academic studies from rural Australia to metropolitan Chicago; from Europe's northern peripheries to healthcare centres in Nepal; from hospital wards to community health; from nurses and midwives to doctors; from physiotherapists to allied health workers. Practitioners and consultants have also given their perspectives on the health workforce, and politicians, of course, have a significant point of view. The occupational experiences in relation to some 40 million health sector workers are covered by these outputs. And if this weren't enough, the fact that 'health' touches every member of the world's population means that it is bound to be a subject that stirs passion and emotion.

But the complexity of the subject means that more needs to be done to improve knowledge at both theoretical and practical levels in how to optimise the contribution of the health workforce. From a general human resources perspective, pioneering work such as that by West and others showed that greater use of complementary human resource management practices had a statistically and practically significant relationship with patient mortality (West et al. 2006). Whilst it is possible to extrapolate this conclusion to talent and talent management, further clarity is needed

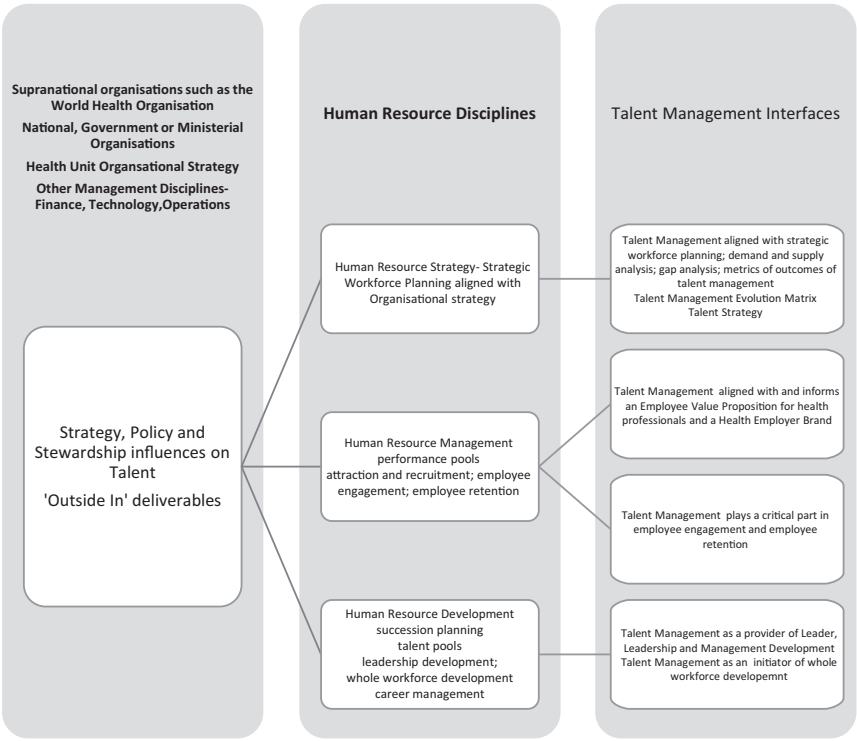

Fig. 1.1 Talent management interactions in the health sector

(Ingram and Glod 2016). Amongst the areas for improvement are defining talent and talent management, the identification of talent, the value of talent management, the importance of understanding talent management across health sector organisations (clinical and managerial) and the level of inclusivity or exclusivity adopted in organisations.

Best Practice or Best Fit?

The diversity of views present in academic and practitioner resource and advice suggests that seeking out and trying to replicate what some would see as best practice would be an obvious approach to the subject of talent in health. But complex cultural or organisational factors and the contexts

within which individual health sector organisations find themselves vary widely, and there are multiple insights about areas within the subject of talent and talent management. Best practice might be so only in a specific organisational or cultural context. For example, whilst a good deal of work has been undertaken on defining talent and the theory of talent management (much of it inconclusive), interpretations vary. This is also the case with respect to talent strategy, the management of talent, attraction and recruitment, engaging talented members of the workforce, and the measurement of the effectiveness of talent management. Additionally, the emphasis on trying to build underlying theories of talent with less emphasis on the outputs of talent management means that identifying best practice in these circumstances would be difficult to say the least. So what options do health sector organisations have?

In reality, talent management is a mix of science and art. The science is derived from psychology and human behaviour, from sociology and organisational dynamics and from economics through analysis of labour market demand and supply. The art is derived from the ability to engage executives, managers and the whole workforce into the practice of talent management. These factors and the importance of context to talent management in health indicate that organisations may choose to go down a path of what is right for them in their particular circumstances. This is best fit, which for many would be more apposite to their specific circumstances, and this is a strong theme throughout the book. Best fit means choosing from a range of scenarios, models or evidence to select the most relevant. It doesn't mean that organisations won't learn from the achievements or successes of 'best practice' others. Nor does it mean that organisations won't aspire to improve and sustain their talent management. It means more that health sector organisations will be confident to say 'that will work for us' or 'that won't'.

The Chapters and Structure of the Book

Drawing from research and practice, the narrative suggests that successful talent management in health will come about from a combination of task-related activities, such as talent planning, recruitment, development

and retention, and relationship activities, such as engaging executives, line managers and talented people themselves.

The chapters therefore include research, examples and case studies from organisations around the world against each of these criteria and from these some generic models that may prove useful. It will be up to every organisation to extract from these the things that they value and can execute in their own unique contexts.

Chapter 2, for example, will discuss the global nature of healthcare in the twenty-first century and some of the key trends that are associated with it. It will set the context for healthcare and start the process of understanding the human resources issues and challenges.

Chapter 3 is concerned with defining talent and how healthcare organisations at supranational, national and organisational level have approached the subject. It will deal with the exclusive/inclusive debate and offer a different approach in the form of a pluralistic definition.

Chapter 4 considers the boundaries of talent management and how these are dealt with in health sector organisations. It will investigate the implications of taking an exclusive or inclusive approach and the elements that will be contained within them for delivering talent management. It will then outline the key elements of talent management derived from a pluralistic definition.

Chapter 5 introduces the talent management evolution matrix as a tool against which health sector organisations can assess their current positions and from these define future objectives which will form the basis of a talent strategy. In this case, the point of best fit rather than best practice is emphasised. Chapter 6 builds on the talent management evolution matrix's outputs and uses these as the basis of developing a talent strategy.

Chapters 7 and 8 are the first two that concern some of the tools of talent management and how these have been applied in health. The subjects of succession management and leadership development are dealt with in the first instance, followed by the concept of whole workforce development.

Chapter 9 addresses how healthcare organisations have dealt with the attraction and recruitment of talent and will cover the issues of the employee value proposition for health and the employer brand and how it has been applied.

Chapters 10 and 11 deal with the process of talent management and how it relates to both employee engagement and employee retention.

Chapter 12 will highlight how organisations in the health sector have enrolled executives, senior and line managers into the talent management process and will also cover the competences needed by healthcare people development, human resources and talent professionals as they go about the job of talent management.

Chapter 13 will draw together the key findings about talent management.

Talent management therefore takes place within a boundary set by the contemporary healthcare proposition, which includes the recognition of the universal right to health and far-reaching global and national health goals and aspirations. Achieving these will require the right numbers of health professionals, with the right skills, in the right place at the right time. But this will mean bridging a talent gap that is both quantitative—not enough surgical, psychiatric or paediatric nurses in Australia or a persistent shortage of healthcare workers in India, for example—and qualitative—shortages of general practitioners and specialist doctors in Canada and Finland, as another—and one that exists in a complex socio-political environment. How organisations address these issues will be the difference between success and failure in both clinical and operational outcomes.

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2

The Changing Landscape of Healthcare

The Transformation of Healthcare

Globalisation, complexity, an imbalance between demand and supply, and organisational transformation provide the context for the provision of health services in the twenty-first century.

These powerful forces have converged to create a challenging environment for the sector as it strives to convert the aspirational goal of Universal Health Coverage, to ensure that all people have access to health services without financial hardship when paying for them (Ferguson 2015), to operational reality. Amongst the most influential forces are the 'human ecology' of disease and its increasingly global impact; the importance of culture and its influence on the type of and approach to healthcare; the impact of people-place interactions (urbanisation and building design, for example); the influence of institutions, governance, policy and biopolitics which are mostly concerned with 'the state's attempt to manage, control and shape biological processes through regulatory mechanisms that generate societal norms' (Connell and Walton-Roberts 2016: 161) and finally mobility as it concerns both access to healthcare services and the mobility of healthcare workers.

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Furthermore, the recognition that the provision of healthcare goes beyond physical and mental well-being and is a vital factor in economic development, global security, governance and the preservation of human rights (Frenk 2010) has accentuated the focus. An effective and functioning healthcare system can move from being a consumption sector to one that can have 'positive returns on the economy and represents an investment with a great potential to contribute to broader poverty reduction strategies' (World Health Organization [WHO] 2013: 28).

The swell created by these factors has led to unprecedented amounts of investment flowing into health (ranging from 1% to 3% of gross domestic product in India and China; to around 8% in the UK and USA; 9% in Japan, Denmark, France and Germany; and as high as 14% in the Marshall Islands), creating the need for professional management and administration as well as clinical expertise to ensure the efficient deployment of resources to primary, secondary or tertiary care. Stemming from these investments, new initiatives have appeared, designed to strengthen national health systems and a strategy to achieve Millennium Development Goals (Frenk 2010). Technology developments in how health is both analysed and delivered will help in the achievement of these goals. Innovative ways of delivering healthcare are being devised and implemented worldwide. But in all cases, success will depend on human resources for health without which national health systems cannot function (WHO 2013: 2). For example, the WHO's Sustainable Goal 3 to ensure healthy lives and promote well-being for all, at all ages, can be achieved only with effective health workforce planning, education, and professional approaches to deployment, retention, management and reward.

External economic forces with respect to the pressures on health budgets; and external people dynamics such as global talent shortages, cross-border mobility and intense competition for skilled health professionals; as well as internal organisational shifts such as multi-generational workforces and the changing nature of governance structures in health will have a significant impact on the ability to deliver human resources for health objectives.

Global Talent Shortages in the Health Sector

There is no single causal factor behind talent shortages in health, and within this broad context, the phenomenon is global in its reach and will require sophisticated national and organisational talent strategies to deal with complex scenarios. From a workforce perspective, the observation that 'there are no more borders' (Ferguson 2015) in health has added a further dimension to the complexity, though changes in the worldwide political order and the effect on labour migration may bring this into question. Staffing levels as well as the demand for education and training (Wong et al. 2015) are issues that affect the achievement of the quantities, qualities and skill mix of the health workforce to match current and future expectations (WHO 2013: 6).

In a broader analysis, the World Economic Forum concluded that there was a possibility of global talent shortages by 2020 in thirteen industries and nine occupational clusters. The extent of these shortages ranged from those with supply chain skills (Dubey and Gunasekaran 2015); distinct regional shortages in China, Singapore, Thailand, Hong Kong and Taiwan (Tatli et al. 2013); and worldwide shortages of those with science, technology, engineering and mathematics qualifications and professionals in such areas as construction. Of particular importance was the health sector, where it was concluded that talent shortages existed in the present day and would continue in to the future unless actions were taken. The effect of labour market forces was excess demand for leadership, managerial, project, specialist and operational talent, highlighting the need to focus on the attraction and subsequent retention of this talent (Turner et al. 2016).

Nor are talent challenges confined to any one country or region:

- In the USA, for example, healthcare has been the fastest-growing sector of the economy. Healthcare reform, including efforts to expand access to healthcare services, has created significant increases in demand (in 2015 the sector added nearly half a million employees and now constitutes one in nine jobs in the USA) and embraces different and new types of health worker which are complementing that for the traditional health skills of doctors and nurses (Lorenzetti 2016). This has

led to a health sector workforce talent shortage, making it one of the sector's most pressing challenges (Simon et al. 2013) Whilst acknowledging that effective competition policy was critical to the success of US healthcare reform, including reducing healthcare costs, increasing the quality of care, and expanding access, it was also noted that the talent gap was exacerbated by out-of-date professional regulation, which acted as an impediment to change among different types of healthcare service providers (Gavil and Koslov 2016). If there are changes in legislation from the new administration, they may not immediately affect talent shortages in the short term and therefore they will remain a critical issue.

- In the UK, three significant government-sponsored reports published in 2015 (by Ed Smith, Deputy Chair of National Health Service [NHS] England, and Lords Rose and Willis in NHS Leadership Academy 2016; Rose 2015; Smith 2015; Willis 2015) each raised the subjects of talent and talent management as being critical success factors for the NHS. Their observations and recommendations focused on not only such issues as the need to ensure that the NHS had well-trained people in leadership roles over the course of a ten-year period but a more inclusive perspective on the development of talent at all levels: a whole workforce approach.
- In Asia, a convergence of factors ranging from an ageing population to different types of disease has led to rapid growth in the healthcare sector and pressure on talent. In Indonesia, for example, annual growth rates of 15% to 18% in health are expected. This expansion is accompanied by shortages of talent, referred to as the 'talent crunch', as shown by a survey of healthcare executives which found that a prime concern was the recruitment of medical personnel at all levels from management to doctors, nurses, and clinical assistants to meet demand (Korn Ferry 2015). Talent migration in and out of Asia presented macro and organisational level challenges (Yeoh and Lai 2008).

The position in India serves as an example of some of the issues being faced as a result of the globalisation of healthcare provision. Healthcare was predicted to be a major driver in the Indian economy and during the 1990s grew at an annual rate of 16%, and by 2020 it is anticipated firstly

that India's healthcare sector will become a US$280 billion industry; secondly that the private sector will drive growth, providing about 40% of healthcare in India; and thirdly that the public sector share will shrink. Growth has been through the privatisation and corporatisation of the Indian Health sector and the development of new business approaches to healthcare delivery. However, these economic growth forecasts are put at risk from the severe talent shortages that are affecting the sector, and it was noted that the scarcity of skilled health professionals was both severe and ubiquitous (Srinivasan and Chandwani 2014). Furthermore, talent shortfalls have been identified at all levels, from doctors to nurses and health technicians. A mismatch between supply and demand (caused by, amongst other things, a shortage of places at medical colleges) and the move of doctors from rural areas and public hospitals to the private sector have created significant staffing challenges. This exacerbates the shortage of medical employees in public healthcare with a knock on effect on accessible and affordable healthcare for poorer sectors of the community (Srinivasan and Chandwani 2014).

In all of these examples, an adequate and performing health workforce is critical in the improvement of the coverage of health services and health outcomes (WHO 2013: xi).

Cross-Border Mobility

The ebb and flow of those seeking health services is matched by a substantial number of health professionals who move within and between countries because of higher salaries, better working conditions, or the provision of better training and career opportunities. The impact is on the composition of the workforce in both sending and receiving countries, which affects the size, skill mix, geographical distribution and workforce profile. The consequences are either to mitigate or aggravate workforce shortages, the skill mix, or the position in underserved areas (Wismar et al. 2011: 1).

In Europe, for example, a number of factors have facilitated cross-border mobility and the migration of health professionals between member states of the European Union (Kuhlmann 2013). Most receiving

countries have seen substantial benefits because flows of doctors, nurses and dentists have increased the ability to provide capacity (in, for example, Spain, Austria and Italy). Whilst 'the UK's recent openness to mobility fulfilled its purpose of improving staff coverage rates. In turn, this is perceived to have contributed to reductions in waiting times for NHS treatment. Second, NHS organizations were able to make financial savings on agency fees for temporary staff and greater workforce stability also enabled increases in the UK's training capacity' (Young 2011: 9). But these benefits are not universal and other countries, including Slovakia, Romania, Hungary, Estonia and Lithuania, have also seen net losses in skilled health professionals. In addition, some specialties—such as anaesthetists and emergency doctors in Poland or child psychiatrists in Belgium—are more vulnerable to shortages (Wismar et al. 2011: 3).

Furthermore, a study of the free movement of health labour within the European Union, for example, showed that there were both positive and negative effects. 'The analysis suggests that there is a risk that free health workforce mobility disproportionally benefits wealthier Member States at the expense of less advantaged EU Member States, and that mobility may feed disparities as flows redistribute resources from poorer to wealthier EU countries' (Glinos 2015: 1529). This is in relation to not just doctors and nurses but also allied health sector workers, and, with healthcare becoming so technologically advanced, the healthcare system needs an increasing supply of highly specialised and skilled technicians (Kabene et al. 2006). In many of these occupations, the attraction, management, development and retention of talent are priorities for employing organisations.

The context for talent management in the world's health sector therefore embraces both the span of services (i.e., the geographic and demographic coverage of health services) and their scope (i.e., the nature of those services). Both are complex phenomena and both have received a good deal of attention from policymakers and researchers alike. However, the role of the effect of these forces on the mobility, lives and careers of health workers is not as well articulated and is an area that would benefit from further study. Indeed, healthcare worker maldistribution (Connell and Walton-Roberts 2016: 163) may itself be considered a powerful driving force in health geography.

To complicate matters further, the transnational reach of medicine, disease and healthcare services means that 'once local problems have become global' (Connell and Walton-Roberts 2016: 158). Global development is as much a feature of healthcare demand and supply as it is of finance and commerce. For some organisations, this presents an overwhelming problem. For others it is an opportunity for transformation.

Different Health Systems Affect the Deployment of Health Professionals

The above narrative highlights a growing demand for health services, on the one hand, and a shortfall in supply of those who deliver the services on the other. Strategic change, such as in the provision of universal coverage in the USA with the triple aim of improving patient care experiences, improving population health and slowing the growth of healthcare costs (Berwick et al. 2008), would be put at risk if a sufficient number of skilled, talented healthcare workers were not available.

In this respect, the location and deployment of the health sector workforce take place in a wide variety of healthcare domains that reflect the scale, scope and culture of health service in each country. For example, whilst around 60 countries offer universal healthcare, the delivery of that care takes place in different ways.

The common denominator of universal health programmes and government action aimed at extending access to healthcare as widely as possible is one outcome; the uncommon denominator is the heterogeneity of health delivery systems. On the one hand, these will be in the framework of a national public health service, whilst on the other, largely private health service provision. For others still, there will be a 'mixed economy' of health providers. The challenges presented by this diversity are compounded by supply issues around public and private provision (WHO 2013: 16) such as the position in parts of Latin America where, whilst private hospitals suffer from underutilised capacity, meaning that managers are concerned with marketing, pricing and demand forecasting, public hospitals are overwhelmed with patients, leading to a focus on capacity, inventories, waiting lists and working capital (Ketelhöhn and Sanz 2016:

3835). And there are demand issues since geographic boundaries are no longer constraints to health service delivery, leading to a growth in the global healthcare market, such as in South East Asia to a value of some US$ 40 billion (Jadhav et al. 2014).

Hence, a single-country, single-delivery model of healthcare with specific but narrow biomedical objectives is no longer the only scenario. Talent management often takes place in a broad multi-service, multi-structure, multi-culture environment and will reflect these variable contexts.

Intense Competition for Talent

The labour market for health professionals is global in its nature, and to date there has been relatively free movement between countries.

Whether such a trend continues in the face of political change (and the possible restriction of labour movement) remains to be seen. What is likely to remain constant though is the convergence of global forces leading to an increasing demand for trained and qualified professionals (Ventura et al. 2015). Furthermore, whilst many global initiatives have been concerned mainly with the direct provision of services, whether they are medical or public health services, transformation also means that health systems will need to perform other enabling functions, including stewardship, finance, and resourcing and what is probably the most complex of all challenges, the health workforce (Frenk 2010). The need to supply a sufficient number to fulfil these roles is a key driver behind the growing interest in talent and talent management.

Over 40 million people work in health organisations around the world (Table 2.1) in occupations covering a spectrum from direct health service providers to those in supporting roles such as technologists or ancillary employees. The British NHS, for example, employs over 1 million people, of which 10% (estimates vary) come from outside of the UK. Countries who are the highest contributors of health professionals include India, the Philippines, Ireland, Poland, Nigeria, Zimbabwe and Portugal (NHS Hospital and Community Health Services 2015). In Germany, the health sector workforce increased by 23% between 2000 and 2012. This was

Table 2.1 A comparison of existing health workforce with forecast demand: 2013–2030 (WHO 2016)

	2013	2030	2030
WHO region	Stock of health workers[a]	Future stock of health workers[b]	Future demand for health workers[c]
Africa	1.9	3.1	2.4
Americas	9.4	14.0	15.3
Eastern Mediterranean	3.1	5.3	6.2
Europe	12.7	16.8	18.2
Southeast Asia	6.2	10.9	12.2
Western Pacific	10.3	17.3	25.9
Total	43.6	67.4	80.2

[a]Estimates from World Health Organization Global Health Observatory
[b]Based on modelled estimates from the WHO
[c]Based on World Bank data

three times higher than any other sector in the economy as a whole. Growth was, in part, staffed by a significant number of doctors born outside of the country, of which the main sources were Romania, Greece, Austria, Russia and Poland, Iran, Syria, Turkey and Ukraine (Kovacheva and Grewe 2015). In the USA, the impact of the demand for healthcare means that employment for nurses is projected to grow 16% by 2024 from its 2014 level; occupational therapy assistants, physical therapists, home health aides, nurse practitioners, and physicians' assistants to grow by 30% (US Bureau of Labour Statistics 2016). To deal with this demand, the number of foreign-born healthcare workers makes up around 15% of the total healthcare workforce. This in itself requires sophisticated talent management processes, but if the free movement of health talent is restricted, then this will place even greater demands to invest significantly more in training and development and on organisations to be radical and innovative in their sources of health worker supply.

The context within which talent management is taking place is one of significant increases in demand for skilled health professionals in multiple labour markets set against transformational change in the organisations that provide healthcare. Thus, the size of the sector and the demand for a growing, constantly changing range of services mean that competition for the most talented professionals is intense. These dynamics apply to

all geographies, although their strength and pace vary from country to country or region to region. There are shortages of health sector workers in both the global south and in the global north that have an impact on how organisations define talent, put in place measures for its recruitment, set up appropriate development and ensure that once talent is attracted it stays with the organisation.

A Diverse Mix of Clinical, Allied and Managerial Health Professionals

The make-up of the health sector workforce worldwide is notable for the diversity of the numbers and types of roles.

The WHO has described health sector workers as people whose job it is to protect and improve the health of their communities (WHO 2006). Their analysis differentiated between clinical roles and a wide variety of what might be called allied health workers. Those associated with the conventional approach to healthcare are classified as health professionals and would include both frontline doctors and nursing and midwifery professionals. In addition, there are those who provide medical health services in addition to doctors and nurses, referred to by the World Health Association as modern health associate professionals. And there are those who provide what is called by some alternative but by others traditional medicine practitioners and faith healers. This group constitute the clinical side of healthcare. However, there are nearly 20 million workers who don't fit in to this category but are integral to the provision of safe and modern services. Unsurprisingly, given the growing incidence of technology in health, there are large numbers of computing professionals but also managers, administrators and clerical support workers.

The current distribution of health workers worldwide, together with anticipated demand in 2030, is shown in Table 2.1. A shortfall of a significant number of health sector workers is predicted over the next 15 years and in almost every region of the world this brings with it existential challenges to those organisations looking to meet rising demand for health services. In the context of a sector characterised by a high level of technical skills, competition for the most talented professionals in a wide range of

clinical and managerial subgroups is intense. This means that the attraction, management, development and retention of talent are areas of great interest to employing organisations not only for the highest profile clinical jobs such as leading surgeons, health specialists and health management generalists.

But the desire of any single health organisation, such as a hospital, in a single country, to ensure that it has a full complement of talented health professionals is framed in the context of ethical and moral issues that transcend nations. So, whilst talent shortages remain a worldwide challenge, there are variations between countries which are persistent. For example, in some countries, the threshold of 34.5 skilled health professionals per 10,000 population is not being achieved; there are skills imbalances across geographies and 'varying capacity in estimating future needs and designing longer term policies' (WHO 2013: 3).

Ideally, the supply of health services would meet demand in equilibrium; that is, there would be enough resources to meet the needs of those requiring healthcare. Fundamental to this would be sufficient well-trained clinical health workers and a supporting workforce in the right numbers, at the right place and at the right time. The quest to achieve this ideal is one explanation of the growing importance of strategic workforce planning in health and the development of talented people to fulfil clinical, non-clinical and managerial functions in health sector organisations wherever they are in the world. As stated previously, the size of the global health workforce is forecast to grow substantially in the next decades because of population and economic growth, together with demographic and epidemiologic transitions (WHO 2016c).

There is, however, a lack of equilibrium between the demand for and supply of healthcare workers which, unless addressed, would inhibit the chances of achieving universal access to healthcare. Research by the World Bank revealed a further complication. In addition to the challenges presented by health workers moving from south to north, there is growing fear of shortages of talent in other areas, and labour shortages are predicted to be severe in middle-income countries and for the East Asia and Pacific region, 'which is anticipated to have a large increase in demand due to a relatively more robust economic growth, rapid population growing and aging, and modest social protection for … private

health spending' (Liu et al. 2016: 11). There were questions as to whether middle-income countries would have the capacity to scale up the supply of health workers to meet demand because of the length of time to educate health professionals to the required levels of qualification.

Two further factors have an impact on the availability and management of talent, namely demographic change and the impact of changes to healthcare systems and governance structures.

Demographic Forces Shape the Health Workforce

Demographic change, different types of organisation structure, global mobility, multi-generation workforces and more diverse, empowered employees have changed the nature of talent management in health across the spectrum from the hospital or health unit environment to the transformation and employment preferences of medical trainees (Newman et al. 2016).

Demographic change is important because declining birth rates, increasing longevity and changes in attitudes on the part of employees have created an unprecedented generational mix in the workforce. Balancing the different development and career expectations of a multi-generational workforce affects the types of talent decision and hence the nature of talent management (although the issue of multi-generational differences has produced some conflicting results). The effects on recruitment, management, development and retention are significant and range from increased expectations from employment (career opportunities, for example) to the implications of the generational mix on human resources activity from training and development to reward, as well as the actual process of managing a multi-generational workforce. In evaluating talent management options in this context, an evidence-based approach is advised. This is because of the complexity of understanding the management of the generational mix. The sometimes pessimistic presentation of intergenerational differences can be misleading. Instead, 'this negative rendering of generational change conflicts with evidence that generational change may bring forth positive developments' (Newman et al. 2016: 270).

Hence, the need to balance different development and career expectations has had an impact on talent decisions and the nature of talent management. This point of view was echoed in Australia where differences in expectations in the workplace by generation found that there was a need for a tailored style (Farr-Wharton et al. 2012), in Canada with a strong emphasis on career advancement on the part of health workers from Generation Y (Lavoie-Tremblay et al. 2010) and in the USA with the perspective that resources and strategies to develop skilled Generation Y nurse leaders would be required (Sherman et al. 2015).

In conclusion, an understanding of the implications of multi-generational workforces will give greater insight into what drives, motivates or hinders health professionals in each generational segment. The implication is that recruiting and retaining a workforce increasingly made up of multi-generational groups 'is a challenge that can be tackled with a deeper understanding of each of the commonly identified generational groups' (Stanley 2010: 846). The key to the success in this area is effective communication, value and respect and, of particular relevance to the subject of talent and talent management, understanding and adapting to different ways of learning, development (Conning and Cook 2012) and career opportunity.

The Effect of New Types of Organisational Structure and Governance

The traditional hierarchical model that was a feature of many health sector organisations, with an element of stability and consistency of relationships, is no longer the sole structural or governance archetype, and a feature of some health sector contexts is the shifting changes in both organisational structures and the networks within which they operate. Hence, health sector governance can be complex and those intending to establish talent management will require excellent navigational skills to negotiate successfully in such an environment. The British health system is an example of such complexity, and the stakeholders who will have an input in the strategic direction of talent management may include the Department of Health, NHS organisations and departments, Public

Health England, Local Governments, the National Institute for Health and Care Excellence, the Care Quality Commission and NHS Clinical Commissioners. Organisational complexity has implications for leadership and management as the adoption of new ways of working within clusters of relationships and informal networks become important as ways to mitigate dynamic behaviour within the environment (West et al. 2015). Such changes also have implications for the competences needed on the part of leaders and managers and, by definition, the approach to talent management.

In addition to matrix and network structures, examples of other organisational forms include those reflected by combinations of profit and non-profit organisations providing healthcare in Italy (Macri and Trimarchi 2016); the impact of privatisation of the management of public health organisations in Turkey (Çınar and Eren 2013); and the role of public-private partnerships in India (Panda 2015; Chakravarty et al. 2015). In the USA, 'innovation in systems for the delivery and reimbursement of health care' have led to a mix of agencies delivered through a combination of centralised, decentralised and combined authority (Hyde and Shortell 2012; Piña et al. 2015: 670). Each of these structures and approaches has implications for talent and talent management.

This diversity of organisational governance is exemplified in the USA by the 2010 passing of the Affordable Care Act, which had an impact on the structure and provision of health services. The Act created a Patient's Bill of Rights, reformed benefits provision for categories of children and young adults, made changes to the processes of insurance companies and ended lifetime limits on coverage. Significantly, the Act enabled greater numbers to seek emergency care at a hospital outside of the specific health plan's network. The US Department of Health and Human Services 2016 noted that the recruitment, training and retention of primary care professionals have been identified as priorities. This activity included the training of new primary care providers, including physicians, nurse practitioners and physician assistants, and over US$14 billion was made available to strengthen the healthcare workforce. There are proposals to restructure health care in the USA but it is unlikely that the demand for health services will decrease and

hence there will continue to be pressures on the demand/supply equation and its impact on the health workforce. Effective talent management in the US healthcare system will require those responsible for its delivery to navigate different types of organisational structure and response to demand and supply.

In all of these examples, the implications for talent management are quantitative in that more people are needed because of the creation of new organisational structures resulting from changes to legislation or healthcare delivery systems and are qualitative, relating to the skills required to work within and between such structures. The various types of health worker now go beyond traditional ones such as doctors, nurses and midwives with the observation that 'much emphasis has been placed on professionalising health workers such as social welfare workers and supply chain managers and on integrating community health workers and other frontline workers in the formal health system' (WHO 2013: 4). Negotiating the hierarchies, networks and matrices embodied within these dynamics will be critical to the delivery of effective talent management.

Global Policy and Local Actions to Address Workforce Challenges

The response to the challenges outlined previously would be a skilled and effective health sector workforce that could match identified priorities, and were aligned to population needs. At its 69th Assembly, the WHO laid out its vision for the shape and constitution of the global healthcare workforce in 2030, noting that health systems could function only with improving health service coverage and the availability, accessibility, acceptability and quality of a health workforce. In this context, the mere availability of health workers would not be sufficient unless they were fairly distributed, had the required competence, were motivated to deliver quality care, had a supportive well-resourced health system and were accessible by the population (WHO 2016).

Outlining that the Global Strategy on Human Resources for Health: Workforce 2030 was primarily aimed at planners and policymakers of

WHO Member States, they addressed issues that were of a global importance, including difficulties in the education, deployment, retention and performance of health sector workforces that would be critical in the achievement of the priorities identified in the post-2015 agenda for sustainable development. But this would be difficult to achieve without concerted action because of shortages both qualitative and quantitative, skill-mix imbalances, what the WHO refers to as the 'maldistribution' of health workers, the persistence of barriers to inter-professional collaboration, and the inefficient use of resources. Poor or incomplete workforce data compounded these issues. Furthermore, there was the observation that investment in health workforces was lower than assumed which had an impact on the sustainability of the workforce and health systems. However, even in high-income Organisation for Economic Co-operation and Development countries, the need for a more accurate understanding of the position for human resources for health has been advocated if effective action was to be taken (Murphy et al. 2016).

Indeed, it was observed by the WHO that health sector organisations should 'reappraise the effectiveness of past strategies and adopt a paradigm shift in how to plan, educate, deploy, manage and reward health workers. Transformative advances alongside a more effective use of existing health workers are both needed and possible through: the adoption of inclusive models of care encompassing promotive, preventive, curative, rehabilitative and palliative services; by reorienting health systems towards a collaborative primary care approach built on team-based care; and by fully harnessing the potential of technological innovation' (WHO 2016).

In this environment, there is a complex set of relationships between health sector policymakers and advisors, political policy and how these translate to organisational execution at the point of care. Proposals to set up a comprehensive health labour market framework for universal health coverage (Sousa et al. 2013) acknowledge the point. However, to achieve multiple goals would require a skilled, trained and supported health workforce driven not only by 'top-down, generalized global strategies and policy guidelines' but by concerted action on the part of frontline providers (Zakumumpa et al. 2016: 1).

The world's health sector is in a dynamic state of flux and it is clear that solutions to health challenges will require not only political will backed by resource on the part of decision makers but also the recognition of the criticality of people to that success. The responses have been measured and strategic as in the case of supranational organisations, but many would agree with the point of view that in the health sector, it is no longer business as usual since healthcare systems are struggling with rising costs and uneven quality. Healthcare leaders and policymakers have tried many fixes but few have had much impact (Porter and Lee 2013).

Talent management is one possible solution to effective human resources for health. At a supranational level, in organisations such as the WHO, a focus on human resources for health has already been strengthened, and within this, processes for increasing the quantity and quality of talented health professionals have been initiated; and at national level, there is a perceived urgency to deal with balancing the demand for health with a 'match fit' health workforce. But it is at an organisational or health unit level that execution of international and national policies takes place and it is at this level that talent management is at its most crucial.

Conclusion and Implications for Practice

The worldwide health sector operates in a complex and rapidly changing environment in which demographic change has impacted on population demand for both health and professional supply of health and political change has impacted on the ability of organisations to source its health workforce and the economic demands for efficiency in the public sector and shareholder value in the private. Technological factors, whilst providing exciting futures, add to the challenge of attracting and retaining the skilled workforce to deliver it.

In this environment, organisations in the health sector sail between the Scylla of worldwide talent shortages forcing a ramping up of processes to attract, retain and develop talent and the Charybdis of ethics and morality asking them not to recruit from other organisations within their region or developing countries. This dichotomy faces both the global north and global south though in varying degrees.

Nevertheless, there are pressures on organisations at the hospital or health unit level to ensure that they meet the demand for health services in their region or area by having talented people in sufficient numbers to deliver the quantity of services and with knowledge and skills to meet qualitative needs.

These twin demands take place against a scarcity in supply of those who deliver the services. The phenomenon is global in its reach and will require sophisticated human resources for health practices if successful outcomes are to be achieved. Talent management is a key constituent of these practices.

But there are a number of important questions that will need to be answered by those with responsibility for delivering healthcare services and ensuring an appropriate level in the global healthcare workforce:

- What is the relationship between talent management and the achievement of supranational, national or organisational goals in health?
- To this end, how can talent be defined? Are there different interpretations of the term in different geographies or organisations? If so, what is the impact and how can this be addressed?
- What is talent management and how can organisations ensure that a sufficient level of resource is allocated to deliver it effectively?
- How is a talent strategy developed in organisations and what are the effects of national or supranational policies on this?
- What practices exist to ensure that possible component parts of talent management are implemented effectively?
- How can organisations justify their investment in talent that satisfies key stakeholders?

In answering these questions, the simple transference of knowledge from 'for-profit business in the USA' to the context of health can be problematic (Powell et al. 2012). The approach will therefore be of identifying both research and practice on the uniqueness of talent and talent management in the health sector and mapping this onto research and practice in other sectors, identifying commonalities where they exist and differences where they don't.

Health professionals across the world work in a constantly changing environment. Traditional skills remain in demand, but new ones emerge for both clinical and technical or managerial roles. Defining talent and talent management, crafting talent strategies and ensuring that there is organisational excellence in attracting, recruiting, retaining, managing engaging and developing talent are critical factors in the delivery of human resources for health.

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3

Defining Talent in the Health Sector

The Significance of Talent in the Health Sector

There are compelling reasons why talent and talent management in health assume a significance that is not necessarily replicated elsewhere.

The level of demand, shortages of talent across a wide range of health sector professions able to supply it, the geographic mobility of health professionals, and the diversity of health service provider governance structures explain why the subjects of human resources in general and talent in particular have emerged as significant areas of interest. Talent management is one of the key challenges for organisations worldwide in a dynamic and volatile market environment (Meyers and van Woerkom 2014: 192) requiring a response that is both quantitative (enough health professionals) and qualitative (with the right level of skills).

The position is further complicated because, whilst some external factors associated with talent resonate across many commercial and public sectors, there are additional, unique considerations for health. In the first place, the inequalities in the balance between demand and supply of talented professionals around the globe requiring an under-

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standing of 'spatial distribution, regulation and global circulation' (Connell and Walton-Roberts 2016: 158) are more prevalent in health than elsewhere. Then there are questions of ethics and morality (in recruitment) raised by the global trend in the migration of health professionals and the accompanying 'international recruitment industry to facilitate the passage of health workers from source to destination countries' (Shaffer et al. 2016: 113). In addition, public scrutiny of the quality of the outputs of talent in the health sector, whether these be clinical or managerial, places an intense spotlight on individual talent. Finally, the levels of training and continuing education, sustaining professional competence (dos Santos et al. 2012; Wilson et al. 2014), and a specific development emphasis across professional groups from surgeons to nurses to medical laboratory technologists (Vanspronsen 2015; Joyce-McCoach and Smith 2016) can be the difference between life and death, and there is the added expectation that talented people in health are competent in dealing with such gravity. Consequently, there is an unprecedented interest in ensuring the right number of people with the right attitudes, skills and behaviours, either as critical components of effective operational management or to support health system transformation (Hassani et al. 2013; Frixou and Charalambous 2016).

Questions about the availability of talented people to deal with health sector challenges are not new, but a convergence of multiple forces, outlined above, has sharply raised their profile. Talent and talent management are now considered critical areas for health organisation success and hence the impetus to ensure that there is the right level of talent to deliver clinical, business or organisational objectives. Increases in investment in the health workforce are advocated to ensure that these challenges are overcome, that wider economic and social development objectives are met and that a level of sustainability in health provision is achieved (World Health Organization (WHO) 2016b: 7).

The questions are, investment in which people, when and where? Talent management has the potential to answer these. To do so will require clarity about what is meant by 'talent' in health.

The Importance of a Clear Definition of Talent

The provision of people-centred health services will depend on optimising the performance, quality and impact of the health workforce (WHO 2016) requiring insights about the type and number of people required. A definition of who would be regarded as 'talent' is an important precursor to answering the questions of where to deliver talent investment and how to manage this over the talent lifecycle (Schiemann 2014). The logic is that a clear definition will inform how an organisation can efficiently allocate its resources, based on the recognition that talent can be the core competitive force of a health organisation's development and the belief that effective talent management could create and sustain competitive advantage in private sector health organisations or facilitate the achievement of externally set targets in public ones. In this context, talent will be pivotal to enterprise success (Martin 2015; Yi et al. 2015; Ingram and Glod 2016: 339; Cascio and Boudreau 2016: 103). Such clarity would also help to move away from 'monolithic workforce management to a more strategic and differentiated emphasis on employees with the greatest capacity to enhance competitive advantage' (McDonnell et al. 2016). It would provide the foundation for an organisation-wide approach to talent or one based on developing key groups of employees (Lewis and Heckman 2006: 139; Ingram and Glod 2016: 345). Finally, it would give coherence to talent management, which in turn would lead to the development of systems and processes aligned to the achievement of the organisation's unique objectives.

But a seemingly essential criterion for successful talent management (i.e., a definition of what is meant by the term talent) has been the subject of much debate within both academic and practitioner circles and challenges remain (Collings et al. 2015: 233). For over twenty years, a definition has been sought that would be robust enough to satisfy the needs of organisations in whatever context and that would give guidance about the competences against which individuals were considered or assessed for talent programmes, which people had the required talent to be appointed to roles in the organisation or to be placed in talent pools for future appointments and the basis for talent decisions (e.g., through

performance or potential). This human capital approach to defining talent assumes that the contribution of people to their organisations (Nijs et al. 2014: 181) determines the proportion of investment in them. And yet, citing various studies of talent and talent management in health, Powell et al. (2013) concluded that there was a lack of clarity, a degree of debate, and no single or concise definition. Talent is variously viewed as human capital, individual difference, giftedness, identity, strength or perception (Dries 2013: 276).

In spite of their importance, the questions of what is talent and what is talent management therefore remain open to interpretation. Understanding the reasons for this, and the options open to those organisations looking to develop talent management in health, are important precursors to the delivery of an effective strategy to address talent shortages. The antecedents of the debate about the definition of talent are to be found in the previous two decades mainly but not exclusively in commercial areas outside of the health sector.

The War for Talent and the Exclusive Focus

The seminal work of Chambers et al. (1998a), partners, consultants and directors of American management consultancy McKinsey & Company, captured the talent zeitgeist of a period in which talent shortages were prevalent from the mid-1990s and initiated a long-running debate about the subject which continues to this day. Explaining why there were shortfalls in the supply of top executives to develop and run organisations, which had been identified as a significant strategic challenge, primarily in the USA, they produced insightful findings which resonated in other geographies and sectors.

In *The War for Talent* narratives (Chambers et al. 1998a, b; Michaels et al. 2001), 'C suite' executives were deemed to be in short supply because of a combination of demographic forces (insufficient people within the normal experience range of executives and senior managers) and demand-side economic growth forecasts. An imbalance between the two created intense competition for talent, at least for those with experience of executive roles, those with the potential to fill executive roles or key specialists

for specific organisational functions. In each case, those with the required level of knowledge, skills, attitudes and behaviour to fulfil such roles were considered a scarce resource. The position was deemed to be so dire that the shortage of executive talent was a threat to business survival (Chambers et al. 1998b).

The intensity to get the right people into leadership positions, combined with the imbalance between the supply and demand of people who satisfied the profile analysis of the leadership cadre, led to a growth in interest in the subjects of talent and talent management beginning in the mid-1990s through to the Great Crash of 2007–2008. The emphasis in commercial sectors was at this time predominantly on the most senior positions in the organisation, referred to as having an exclusive focus, and reinforced the importance of ensuring that organisations had a supply of Top Management Talent (Joyce and Slocum 2012). Subsequent interest in talent and talent management generated a wide range of views from both practice and academic literature. In particular, there was a search for clarity of understanding about the concepts and theories that would underpin their validity. Parallel streams of activity considered the questions of what is talent, what is talent management and what are the outputs that result from its implementation?

Talent was defined by, for example, the UK's professional organisation, the Chartered Institute of Personnel and Development, as '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' (Tansley et al. 2007). This discussion was focused on talent at the organisational rather than the individual level (Sonnenberg et al. 2014), but attempts to define talent have also been couched in terms of natural ability, mastery, commitment and fit (Ingram and Glod 2016: 340), performance, competences, capabilities and commitment (Huselid et al. 2005; Ulrich and Smallwood 2011; Björkman et al. 2013: 195). Questions have been raised as to whether talent is the result of nature or nurture and whether it is innate or whether it can be taught and developed. There was the view that talent emerges from the transformation of individual aptitudes to systematically developed skills (Duffy 2016) and that this was most likely a combination of cognitive, affective and conative traits that 'in turn,

determine the direction, intensity, duration and effectiveness of practice/learning' (Ackerman 2014: 16).

These interventions, whilst providing a wealth of material and prompting significant debate for academics and practitioners alike, didn't resolve the paradox of whether those who could 'make a difference' were the executives and senior managers at the top of the organisation (where talent management was directed to this group, known as an 'exclusive' approach) or all employees (where talent management was targeted in this way, known as an 'inclusive' approach). Nor was sufficient attention given to the subject of talent at the individual level, the main focus being on that of the organisation. Nevertheless, the limitations were recognised and considerable effort has been put into developing both theoretical and practical bases for talent. Attempts to clarify the differences in impact of the exclusive/inclusive paradox and to provide an evidence-based construct for talent management have led to a good deal of work on its theoretical foundations. Some of the questions raised in this regard are 'does talent refer to people (subject) or to the characteristics of people (object)? Is talent more about performance, potential, competence, or commitment? Is talent a natural ability or does it relate more to mastery through practice? Is it better to take an inclusive or an exclusive approach to talent management?' (Gallardo-Gallardo et al. 2013: 291).

Broadening the Scope—The Move Towards Inclusivity

The intensity of interest as the concepts of talent and talent management gained traction within organisations and within the human resources and learning, training and development professions (Farndale et al. 2010) led to the opinion that the exclusive view of the definition of talent, relating to a few people in key, pivotal or critical positions, was inadequate in encompassing the wide range of workforce scenarios that were being experienced. Furthermore, the private sector contexts didn't completely explain the experiences of public or not-for-profit organisations (although

there was and continues to be some overlap). The subject of talent definition therefore came under greater scrutiny.

Recognition that talent management was a strategic issue (Cappelli 2008; Collings and Mellahi 2009; Cascio and Boudreau 2016), the perceived inequality of having only a few people as being identified with talent in the exclusive approach (Gelens et al. 2014), the experience of global organisations in their quest to fill the roles of global specialists (such as project managers who were able to manage across cultural and geographic boundaries), and the recognition that there were talent shortages at many levels brought about reflection on the approach to talent. A research agenda focused towards a more comprehensive, inclusive, perspective on talent was proposed. This was reinforced by the conclusion that a clear definition of talent was 'difficult to achieve in practice, as organizations often derive their own conceptualization of what talent is, rather than accept a universal or prescribed definition' (Iles et al. 2010: 179). In many cases, the definition of talent was likely to be organisation-specific (i.e., a contingency approach).

Consistent with this, McKinsey's study (2009) went some way to explaining the paradox and identified several broad definitions of talent encountered in their client organisations. Amongst these was a definition in which everyone in the organisation should be regarded as talent. This option provided for greatest contribution of the full potential of the workforce, with an upside of inclusivity, diversity and no discrimination; a further definition refined this to those employees who were deemed to have high potential regardless of where they sat in the organisation and at what level. These two were at one end of a continuum of talent definitions. At the other extreme was a definition which was more exclusive in approach and defined talent as top management, high potentials and specialists on all levels. A predominant feature of this analysis was a hierarchical organisation structure in which talent was fed upwards through the system.

Ulrich and Smallwood's (2011) research refined the approach and proposed a model which identified talent segments to facilitate the efficient allocation of resources across the organisation. The segments included Executives, for whom individual learning experiences could be

developed which would include executive coaching; a leadership cadre, defined as the next generation of executives and managers whose development would include a focus on shaping the future, making things happen and engaging the existing talent in the workforce; high potentials in either technical or managerial roles; and finally all employees who were likely to benefit from a talent culture in which opportunities to develop are prevalent. In this analysis, talent covers a wide span of the organisation and the management of talent was a whole organisation enterprise.

The many different approaches to defining talent led to the conclusion that the subject was complex, ambiguous and incomplete and that the search for a single definition to achieve 'one size fits all' would not be possible (Ross 2013). However, in an attempt to move this debate beyond the exclusivity versus inclusivity schools of thought, several propositions have been put forward from the concept of 'talenting', which goes beyond the object/subject distinction by making it an inter-subject process (Gold et al. 2016), to value creation and deploying talented people into strategic jobs with the most potential to achieve this (Collings and Mellahi 2013). Nevertheless, the answer to the question of what is talent, whether it is a concept that applies to a small group of individuals in 'key' positions or to a wider group encompassing the whole workforce, remains unresolved.

The evolution of the definition of talent from the mid-1990s has seen the focus shift from a select few at the top of the organisation to others outside of the top management team such as those with specialist skills; those with skills in project, people, technology or supply chain management and other technical functions; or those with specific non-technical competences such as the ability to work in multi-cultural teams. There is a growing expectation that talent is a term that can apply to the majority of the workforce and that this can be a powerful force for organisational performance. And so the extremes of talent being defined only as leadership or managerial positions on the one hand or as any capable employee contributing to the organisation's objectives (Urbancová and Vnoucková 2015) on the other have melded together in the answer to this most fundamental question of what is talent?

Reconciling the Exclusive/Inclusive Paradox—A Pluralistic Definition of Talent

The lack of clarity or consistency about what is understood by the term talent and what comes within the remit of talent management has presented challenges when converted into practice because of fragmented rather than unifying theories (Collings and Mellahi 2009; Tarique and Schuler 2010). To compound matters, a good deal of talent management analysis in the past was concerned with for-profit organisations and 'transferring findings to other contexts such as the public sector in general (*and the health sector in particular*) is extremely problematic' (Powell et al. 2013: 292).

These reasons explain the continuing level of interest in the area. But the focus on the debate between exclusive or inclusive approaches to talent in both academic research and organisational practice may have clouded the view. Whilst 'input' in the form of a general theory of talent is important and work on this subject continues, there has been less emphasis on output; that is, what effect does talent management have on organisations and individuals regardless of how it is defined? This is reflected in the inconsistency in or even lack of measures of effectiveness of talent management. And so it is perhaps to the area of contextual definitions, related to organisation-specific outputs, that attention might be directed. This will provide practical benefit because organisations are faced with the difficult challenge of trying to balance the seemingly irreconcilable forces of sufficient people in 'pivotal' or strategic roles—namely general management, executives, their successors and high potentials—and at the same time creating a culture and practices designed to maximise the talents of all members of an organisation or geographic group irrespective of whether they are on a critical list, a succession plan or members of a talent pool.

The resolution to the paradox, at this point in time, resides within each organisation because organisations define talent from different perspectives. Indeed, a recent study concluded that the one-dimensional and narrow approach to talent (and talent management) could be seen as a

limitation of the talent management literature and recommended a multi-level, multi-value approach (Thunnissen et al. 2013). It is this final piece of analysis that appears to offer the best contemporary route forward to health sector organisations.

This perspective puts forward a view that talent would inevitably be a context-specific term. Particular geographic forces or organisational situations would have different implications for the approach to talent and its definition. Furthermore, the hierarchical basis of much previous work on talent definition would not always apply where organisations had different types of structures—functional, global divisional or geographic, project-based, network or matrix. The talent requirements could be different from one to another. Traditional talent pools of high potentials based on the ability to move up one or two levels may still be required but are supplemented by the demand for people who could move laterally between parts of the organisation (Turner and Kalman 2014), who could work as part of a project team or cross-culturally, talents not always associated with the traditional, exclusive approach.

The contextual nature of the definition of talent management therefore points to a nuanced, pluralistic perspective (Thunnissen et al. 2013). In this, the talent definition would take account of the unique context of organisations and on the one hand provide for the selection of individuals for key roles, such as those identified in succession plans, whilst on the other provide opportunities for the majority of the workforce. It would be a 'multi-level, multi-value' approach to talent definition which has its basis on emphasis rather than exclusion; that is, specific circumstances dictate that, at a point in time, organisational effort will be towards a specific organisational need such as developing leaders for future projects because it is critical to the long-term success of the organisation but that this does not take place at the expense of providing support and development for other members of the workforce, the majority, who are important for immediate performance and have potential for the future. The challenge facing health sector organisations is to define talent in a way that supports the achievement of their own specific objectives.

Case Study: Talent Management in Polish Healthcare Organisations: Exclusive or Inclusive or Both?

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A growing issue in the talent literature is the incidence of inclusivity or exclusivity in definitions of talent and talent management. As Dries (2013) points out, the basic problem in this regard is whether talent management should encompass all participants of the organisation or should be addressed to a clearly identified pool of employees on the basis of demographical, performance or potential criteria (Swailes 2013). A research study of health sector organisations in Poland addressed this issue in the country's unique context.

Over the past 25 years, Polish healthcare organisations have undergone a dramatic transformation caused by new legal regulations, a growing demand for fast, high-quality services and increased competition between the public and private sector.

One of the aspects that required action was the state of employment. Just after Polish accession to the European Union, young, well-educated and respected doctors started to see their career opportunities abroad, in other, highly developed European countries. Overemployment was quickly replaced by underemployment, and currently healthcare organisations struggle to attract and retain doctors, medics, residents or nurses. Thus, in recent years, healthcare organisations in Poland have paid significant attention to improving human resource management policies and practices and focused on developing suitable solutions to the problem of recruiting and keeping employees. Talent management has been part of this solution.

In 2016, a study of healthcare units using the Eisenhardt methodology (1989) identified distinguishing features of talent management in Polish healthcare organisations and concluded that, firstly, in most cases, talent management programmes were in the early stages of development which may be attributed to the fact that the state of human resource management policies and practices in general was relatively modest. Therefore, healthcare organisations tend to focus on improving their human resource management systems, and talent management was perceived to lay beyond that scope. Secondly, healthcare organisations defined pivotal positions, but top performers or talents are rarely identified and infrequently take key positions in organisations. This may be the result of limited performance evaluation practices in most cases, meaning that it was difficult to identify and promote high performers. The performance evaluation was also hard to implement due to the role played in publicly owned healthcare units by the trade unions that, in general, have aggravated the introduction of such solutions. Moreover, pivotal positions are usually distinguished mainly for medical roles and not with respect to administrative ones.

In terms of identified pivotal positions, healthcare units tend to adopt an inclusive approach to talent management, which indicates that everyone demonstrating adequate competencies and past performance may be promoted to important positions in an organisation. However, in studied cases, decisions regarding individual employees were largely made on the basis of subjective opinions. Finally, research results indicate that activities undertaken under the label of talent management were essentially associated with training and motivational instruments. In particular, studied organisations aimed mainly in knowledge and skills improvement, and this training was focused more on organisational needs than on individual ones. Within the scope of the research, it was possible to conclude that healthcare units were in the early stages of introducing talent management programmes, policies or practices.

In the context of the Polish health sector and business environment and given the influential standpoint of trade unions in public healthcare organisations, the solutions developed in such units were most likely to be inclusive, as defined by Iles et al. (2010). Inclusiveness of talent management in Polish healthcare organisations means that managers tend to perceive employees as similarly capable of holding pivotal positions and equality of chances for everyone employed within the organisation. Trade unions in public healthcare organisations have the capacity to influence important organisational decisions, and they are highly effective in forcing their opinions in the case of human resource management issues.

This issue looks different in privately owned healthcare organisations. In such units, trade unions are rare, and reflecting the market orientation of managers of such organisations, talent management programmes appear to be organised in a more exclusive way.

In conclusion, talent management in Polish healthcare units is still in an early, developmental stage. Solutions are evolutionary and phenomenon-based, responding to rather than anticipating change. The development of talent management programmes will most likely be different for public and private healthcare organisations. In public organisations, the introduction of talent management programmes will be influenced and controlled to some extent by trade unions, thus affecting managerial capabilities to make important decisions in this regard. On the other hand, privately owned healthcare units will most likely adopt solutions proposed or suggested by their managers. However, sooner or later, healthcare organisations will focus on developing talent management solutions, but their shape and content are difficult to predict. Given the transfer of solutions between countries and companies, it is more than likely that healthcare units will adapt policies and practices created elsewhere with private sector healthcare units at the vanguard.

Defining Talent in the Health Sector at Three Levels

The war for talent that was a feature of the global commercial system was also present in the global health system with the added dimensions of pressures for ethical recruitment and the implications of developmental economics. Significant shortfalls in the quantity of available medical talent at this time created a burgeoning demand for talented health professionals in Europe and North America. The demand was met in part by the movement of skilled health professionals from south to north, and referring to this as a 'global treasure hunt' or 'disaster-in-the-making', the International Council of Nurses noted that the resulting talent shortages and labour maldistribution had led to a growth in international recruitment of nurses that satisfied short-term needs of those countries and organisations able to do so but at the same time had potentially serious effects on the health of some national populations (Kingma 2001). The Philippines, a country which graduated a substantial number of nurses each year, suffered perennially from a shortage of nurses because of their departure to other countries (Ortin 1990); the shortage of medical staff in Malawi affected the country's ability to deliver on its Essential Health Package and also to absorb international health funding (Record and Mohiddin 2006); and the flows of physicians and nurses from African countries to Europe and North America proved to be deleterious (Kalipeni et al. 2012).

In this respect, the health sector, as others, wrestled with the question of 'what is talent?' In the above examples, the definition of talent depended on specific contexts or phenomena in a geographical area or within an organisation. In some cases, talent was defined in a general way to mean the majority of the health workforce, and in this respect the terms talent and human resources were largely interchangeable; in other cases, talent was defined in terms of specific clinical roles at either a country or a professional level (for example, nursing professionals or medical specialists); finally, talent equated to either operational or clinical executive leaders.

These were needs-based or phenomenon-driven talent management definitions, which were the outcomes of a sequence of challenge (a shortage

of a particular clinical group, for example) and response (recruitment of specialists from other regions or internal training programmes). It is possible to trace this interpretation at three levels:

- Firstly, in supranational organisations such as the WHO or European Union, there has been a strong focus on talent in its broadest sense (i.e., covering many different types and level of health professional). This perspective is reflected in the inclusivity of the three main pillars of the WHO human resources strategy, which are attracting talent, retaining talent and an enabling working environment. In this global context, talent takes on a pluralistic hue which means attracting 'the right people to carry out its work and to implement its global strategy in a timely and successful manner' (WHO 2013: 2) at all levels of the health sector organisation and with an emphasis on gender balance and diversity to ensure a fair and transparent process promoting equal opportunity for all. On the one hand, at a strategic level, a comprehensive definition of talent, influenced by wholesale skills shortages, can be found in the WHO or European Union approach. In this regard, the term talent might refer to senior clinicians to lead health organisations but simultaneously to the development of nurses to fill demand for health services across multiple geographies. On the other hand, the definition of talent might be issues-based, sometimes aligned to short-term health crises or directed towards longer-term perceived gaps in a particular area or anticipation of strategic developments in, for example, new technologies in health or new methods in the treatment of disease. This pluralistic point of view about talent is embodied by the recommendations of the 69th World Health Assembly, which, in response to a forecast shortfall of health workers by 2030, recommended a strengthening of health workforces through national health, education and employment policies (WHO 2016b); efficient investment in and effective implementation of health workforces; optimising the capability of the current health workforce; forecasting and closing talent gaps; providing effective governance of human resources for health; and creating effective human resource metrics. At this level, the role of the WHO, European Union (National Health Service

(NHS) European Office 2016) and others in talent management is one of policy advice and stewardship of health professionals as a whole.

- Secondly, where it is possible to identify a national health approach to defining talent, this is again phenomenon-driven in response to specific challenges. In the British NHS, for example, talent management was considered, in its first incarnation, to be a critical factor in addressing leadership issues in terms of recruiting and retaining executives (Powell et al. 2012). This was an exclusive focus on those who had a 'disproportionately positive impact on the organisational performance' (Powell et al. 2013: 293). But as the concept of talent evolved, there was recognition of the need to develop a broader section of the workforce in a more inclusive way. The argument for an exclusive approach was to ensure a pipeline of those able to fill leadership and managerial positions; the argument for the inclusive approach was that the recognition and development of the unique talents of the whole workforce in the delivery of objectives would lead to reach prime performance (Wilson 2012). The 'Smith', 'Rose' and 'Willis' reports in the UK in 2015 were concerned with the need to ensure not only that the NHS had sufficient numbers and quality of people in leadership positions (because of the high level of change that had been experienced in the organisation and likely to continue in future), expressed as the need to find and nurture the people who are needed to lead the NHS over a ten-year period (Rose 2015), but also that all employees could achieve their full potential. In the British NHS, the concepts of talent and talent management have evolved and continue to do so. A focus on leadership positions was complemented by the need, identified some time ago, to develop managers and to identify and nurture talent at all levels (Birchenall and Parrish 2004). There is further support for the idea of phenomenon-driven talent management at a national level through responses to the shortage of skilled health workers in Asia (Yeoh and Eng 2008), health researchers in Canada (Grant and Kronstal 2010), academic medicine in the USA (Fox et al. 2011), on key positions in Slovakia (Taha et al. 2015), or in Egypt, where the definition of talent included physicians, nursing and administrative staff and research found that there was no discrimination amongst the employees with

respect to talent management (Nafei 2015). The American Nurses Association and the American Public Health Association have advocated a pluralistic approach to talent management in response to demand and supply issues (Mensik and Kennedy 2016). In some cases, the phenomenon of talent shortages led to an exclusive definition of talent, in others to a more inclusive one 'in which organizations would help all employees rather than only people in key positions because all nurses in different hospital sectors can benefit from different talents' (Nojedeh and Ardabili 2014: 8) or recognising the 'inherent talent and strengths when making selection decisions for nurses based on organizational culture and individual values' (Thompson et al. 2015).

- Thirdly, at an organisational or health unit level, the definition of talent was once again mostly phenomenon-driven and as such could be inclusive (Haines 2015) in which talent was 'a consistent pattern of thoughts, feelings and behaviours … that can be developed to reach full potential' (Thompson and Ahrens 2015: 48) or exclusive as in hospitals in The Netherlands, where the definition of talent referred to people who performed above average, were creative and self-starting, showed leadership initiative, had high levels of ability and expertise and were aspirational (Sleiderink 2012). In Poland, where even though medical, managerial, administrative and ancillary positions were important for the organisations to achieve their goals, the focus was on 'mainly pivotal positions' (Ingram and Glod 2016: 344) and in the USA and Canada where talent was identified as current and emerging leaders to create a future vision (Capuano 2013: Fitzsimmons and Rose 2015: 35) on the assumption that 'if intellectual capital is the currency of the twenty-first century, identifying and developing EHLs must be a strategic objective of innovative and progressive health organizations' (Hunt et al. 2011: 4). In reality, most organisations will not have talent definitions that are purely the binary exclusive or inclusive options. Instead, a more pluralistic point of view will be adopted, influenced by the position of the organisation in its talent management evolution (i.e., embryonic, growth, or mature) (Gallardo-Gallardo et al. 2013). In the pluralistic model, strategies to combine individual and organisational approaches to professionalism are

achieved through a focus on systems because, as in the USA, 'organizations that strategically cultivate an organizational culture based on respect, trust, inclusion, and mentoring in career and leadership development are more likely to retain talent' (Brennan and Monson 2014: 646). The US Mayo Clinic, where recruitment is based on career rather than job, 'makes a significant upfront investment in carefully selecting and developing new staff based on an assumption that most will be long-term employees' (Berry and Seltman 2014: 146). These approaches reflect a definition of talent in which both individual and organisational needs are recognised.

At each level of health sector governance (namely supranational and national, professional or organisational), the 'highly labour intensive constitution and the need for the provision of appropriate health workers' (Connell and Walton-Roberts 2016: 163) have converged to generate a significant focus on the healthcare workforce and specifically on talent and talent management. In healthcare, an agreed, organisation-wide definition of and strategy for talent might therefore be regarded as the foundations on which a successful talent strategy can be built. Such a platform would facilitate greater clarity about where resources should be targeted and, because of this, to whom those resources will provide most benefit. The overall objective of definitional and strategic clarity is to maximise the potential of talented people. The questions are which people, where and when?

It is in this area where, like other sectors, health sector organisations have not adopted a particular definition but instead have opted to choose the one that is the best fit for their own specific circumstances.

A Working Definition of Talent at an Organisational or Health Unit Level

The challenge of defining talent at an organisational level is framed by a context that is unparalleled in most other sectors, externally because of the forces for change outlined earlier and internally because 'contemporary

hospitals and clinics are capital and labour intensive, involving complex workplaces and crucial issues of skill, status, experience and hierarchy, and gendered distinctions typify different occupations in various settings' (Connell and Walton-Roberts 2016: 163). On the one hand, external forces regularly blow into well-laid plans, including shifting priorities, new technologies requiring new skills and, through it all, increasing social expectations of the patient experience. On the other, complex organisational forms compound internal dynamics and have an effect on how talent is defined. At a health sector unit level, therefore, evidence suggests that talent is defined from the context of the organisation and not by an external set of rules or guidelines.

It is possible to conclude that the definition of talent in health is largely phenomenon-driven with the added dimension of the specific context of the organisation, its maturity or history and prevalent or dominant organisational dynamics reflected in a resource-based view, international human resource management, a strengths-based approach or social exchange theory. Over time, an initial focus on the definition of talent, which was predominantly exclusive, is moving to a more inclusive whole workforce approach and, in turn by a refining of the concept, to one that is increasingly pluralistic. Overall there is some evidence that the definition of talent in the health sector is taking more account of the demographic trends and recognising that an exclusive-only focus might preclude talented people, who aren't executives, high potentials or fast trackers, from being part of talent development initiatives.

In this respect, a working definition of talent might be proposed as:

> Talent in the health sector refers to those people whose professional expertise delivers positive patient or societal outcomes and whose operational competence and performance create stakeholder value for the organisation.

This allows for different contexts, a pluralistic approach and the scope to adapt to circumstances. In informing this position, a realist view of talent definition has been adopted. In this perspective, the review of talent definitions has shown a broad range of findings leading to 'what works, for whom, in what contexts, to what extent, and most importantly how and why?' (Willis et al. 2014: 516).

Conclusions and Implications for Practice

Having a clear definition of talent will allow health sector organisations to develop a talent strategy and allocate resources in the optimal way. It is a precursor to developing a talent strategy and implementing talent management effectively. Figure 3.1 shows how the various contexts have been translated to positioning in talent definition.

This is because talent in health is largely driven by phenomena ranging from the need for transformational leadership to deal with the wholesale changes and demands that are a feature of the contemporary health environment, or in response to specific workforce 'segment' challenges such as nursing shortages, or in response to a specific event (pandemic) or change (technology). Hence, defining talent in the sector has to take

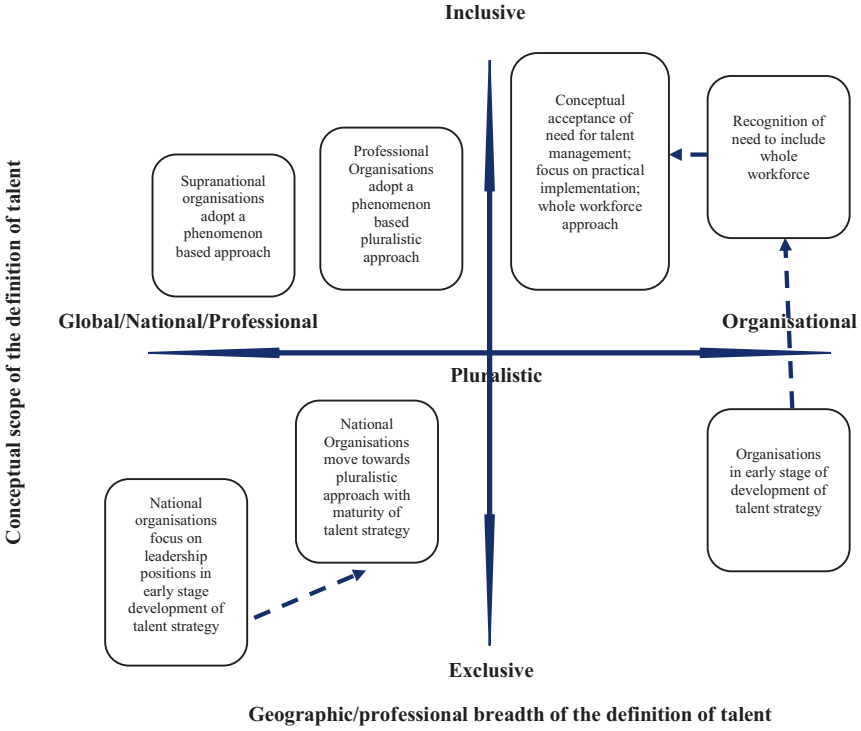

Fig. 3.1 The evolution of talent definitions in the health sector: summary

account of the various external forces and internal dynamics. Developing a talent strategy for a health sector organisation therefore has more moving parts than most other organisations.

However, it is important that a definition of talent is understood and recognised within each organisation. This will provide a foundation on which talent strategy and talent management can be built. The definition outlined above is intended to provide flexibility within a broad framework and the implications for practice at this stage are that:

- Having a clear definition of what the organisation means by the term talent is an important foundation on which subsequent strategies and actions will be built. This rests on the principle that the systematic identification of talent will facilitate the development of tools and techniques for talent management and the adoption of such techniques throughout an organisation, which in turn will be important in the delivery of the organisation's objectives. These will be enhanced by the development of an integrated, proactive approach to talent management based on clarity about the definition of talent.
- But there is no universal solution to this challenge. The definition of talent will be contextual from one health sector organisation to another. In some cases, an exclusive approach will be necessary; in others, an inclusive one. In most, a pluralistic approach which embraces both exclusive and inclusive elements is likely. Talent management in health will be driven largely by phenomena that affect a single organisation or groups of organisations. One phenomenon that affects all is the need to develop more talent at the point of care and this has received worldwide attention from supranational organisations.
- The context within which talent management takes place will be critical in understanding the issues involved and how to deal with them. For successful talent management to be implemented, the organisation should take account of the environment in which it is operating, the impact of factors such as technology developments, and their impact on immediate- and longer-term talent needs (Lockwood 2006).
- Pluralism of talent definition brings with it challenges in terms of resource allocation, and recognition of the likely trade-offs between

competing demands for talent investment is a consequence. A process for health sector organisations to make decisions about these trade-offs would appear to be necessary.

In conclusion, there is no one right answer to the question of what is talent in spite of decades of research and practice. But it is essential for organisations to have a definition of talent that is the best fit to their own circumstances. This calls for a realist or a rapid realist perspective and the adoption of a contingency-based approach. Once organisational clarity about what is meant by talent has been established, the development of appropriate tools of talent and the allocation of resource can be undertaken which in turn will form the basis of talent management.

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4

The Boundaries of Talent Management

Framing the System of Talent Management

That the definition of talent is largely phenomenon- rather than theory-driven has implications for what specifically is included within the boundaries of talent management and the operation of talent systems and processes.

Where talent refers to the most senior roles, perhaps based on the need for a credible succession plan, the priority is to ensure that there are enough people at the right level to lead and manage the organisation. In this example, talent management is concerned with attracting leadership talent, their development and retention. Referred to as the 'exclusive' approach (focusing on a few people), this has been the most common perspective on talent management to date, possibly because 'decision-makers struggle with the philosophy and practicalities of inclusive talent programmes such that exclusive forms may dominate simply because they are much easier to conceptualise and implement despite the implications for the majority they leave behind' (Swailes et al. 2014: 529). At the other end of the talent spectrum, for those organisations with a more inclusive approach, talent management extends throughout the organisation and has a remit based on creating an employee value proposition

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concentrating on career and professional development opportunities for a broad swathe of employees. Some organisations take a pluralistic view about talent management which contains elements of both exclusivity and inclusivity, focuses on organisational needs such as effective and sustained leadership (people and roles) but at the same time seeks to satisfy individual needs through employee engagement and the provision of career opportunity to the majority.

The Search for a Theoretical Foundation for Talent Management

To provide meaning for the concept of talent management, practice-based organisations such as the UK Chartered Institute of Personnel and Development (CIPD) have interpreted it as 'the systematic attraction, identification, development, engagement, retention and deployment of those individuals who are of particular value to an organisation, either in view of their high potential for the future or because they are in business critical roles' (Tansley et al. 2007: 8) and the US Society for Human Resource Management (Lockwood 2006) framed talent management in the context of implementing strategies to increase productivity through systems and processes for attracting, developing, retaining and deploying people with the particular skills and aptitudes to meet business needs. In Asia, nearly three quarters of organisations surveyed had talent management activities (with a higher proportion in China and South Korea) whose primary definition concerned developing high-potential staff and retaining key executives (CIPD 2012). The diversity of views reinforce the conclusion that 'ambiguities regarding definitions, theoretical frameworks, and empirically based recommendations for the use of talent management in practice persist' (Meyers and van Woerkom 2014: 194). To address such an important point, academics have sought to underpin definitions of talent management in practice with those of talent management in theory.

Definitions from academic research tend to fall within one of Lewis and Heckman's three streams of thought. Firstly, talent management as a

'collection of typical human resource department practices, functions, activities or specialist areas such as recruiting, selection, development, and career and succession management' (Lewis and Heckman 2006: 140). The second concerned the creation and development of talent pools; in the third, 'organizations are encouraged to manage performance pools of talent generally rather than succession pools for specific jobs' (Lewis and Heckman 2006: 141).

Within these broad themes, talent management has been portrayed as 'all organizational activities for the purpose of attracting, selecting, developing, and retaining the best employees in the most strategic roles (those roles necessary to achieve organizational strategic priorities)' (Vaiman et al. 2012: 926) or the activity which systematically utilised complementary human resource management policies to attract, develop, and retain individuals with high levels of human capital (e.g., competency, personality, motivation) consistent with the strategic direction of the multinational enterprise in a dynamic, highly competitive, and global environment (Tarique and Schuler 2010: 124). Collings and Mellahi (2009: 311) articulated talent management as processes for the identification of key positions which significantly contribute to competitive advantage, the development of talent pools to fill such roles, and a human resources architecture geared to filling these positions, a definition which emphasised so-called 'pivotal' positions. Meyers and van Woerkom had a similar point of view, noting that 'talented' in practice often meant high-potential, strategically important employees or employees in key positions (2014: 192). Talent management was also identified as integrated, selective human resource management which for many involved an exclusive-people focus on certain groups of high potentials. In many cases, talent management was based on a human capital approach and aligned closely with the business or organisational strategy (Vaiman et al. 2012: 925).

But others have taken a more inclusive stance emphasising 'organizationally focussed competence development', concentrating on talent flows and development, and from a social capital perspective taking account of contexts and relationships as well as human capital (Iles et al. 2010). Recent studies have highlighted how organisations develop pools

of talent and ensure that the organisation had a talent mindset (Sparrow and Makram 2015; Cascio and Boudreau 2016).

Defining Talent Management in the Health Sector

Talent management definitions in the health sector mirror those outlined above. On the one hand, it has been framed by the practices associated with human resource management such as strategic workforce planning, reward, recruitment and training. On the other, talent management refers to those activities associated with executive or high-potential development. In most cases, the foundation for talent management is the anticipation of the demand for human capital and then plans to meet it (Cappelli 2008). The challenge facing health sector organisations is the breadth and depth at which this anticipation takes place, how far into the organisation should talent management go and to where should resources be allocated to deliver the optimum return on scarce resource. Furthermore, contextual factors have a strong influence on how talent is defined and operationalised (Poocharoen and Lee 2013).

At a strategic level, talent management in the USA was defined as a driver of organisational performance by promoting a systemic approach to building the workforce as a critically important resource (Fox et al. 2011). Such a definition is aligned to the use of strategic workforce planning (Gillespie et al. 2013, Fitzsimmons and Rose 2015), although there is still work to be done at both the country and organisational level for the full benefits of this process to be felt (Lopes et al. 2015). In the UK, talent management in health was defined as 'attracting and integrating highly skilled workers and developing and retaining existing workers' (Powell et al. 2013: 291). At its most developed, strategic talent management in health reflects the recommendations that came out of Ingram and Glod's (2016) study emphasising the maximisation of the potential of all employees with talent management programmes, embracing a large number of possible solutions and healthcare organisations considering both individual and organisational needs.

Other approaches and definitions of talent management vary from exclusive to inclusive and shades in between.

An interpretation of many definitions of talent management might conclude that whilst they have been formulated to satisfy a broad range of environments there is a tendency towards an exclusive approach. But the assumption that talent readiness is vital for success and that talent agility is a critical factor in organisational development and sustainability (Martin 2015)—both of which imply 'readiness' at levels other than leadership and high potential—means that there is recognition of the need to broaden the scope to a more pluralistic one (Gallardo-Gallardo et al. 2015).

Often this can be phenomenon-driven talent management and associated with specific groups to deal with operational challenges. These might include the recruitment of specialists such as radiologists, against a set of talent competences, including commitment, skill, and specialised knowledge (Nojedeh 2015), and talent management for doctors in Malaysia's public hospitals where the success of healthcare was closely and naturally identified as being related to development and competence and where talent management was focused on training through a cognitive schooled approach that emphasises competence-based development (Subramaniam et al. 2015: 2). The development of a 'talent tree' to enable the continuous professional development of doctors in China (Yi et al. 2015), the recruitment process which aligns nursing talent with organisational culture and individual values (Thompson and Ahrens 2015), or talent management initiatives aligned to staff optimisation and the management of workflow (Rodrigues 2015) are further examples in which talent management is focused on a particular group of health professionals against a specific phenomenon (usually a shortage of specialists).

The second aspect of phenomenon-driven talent management is focused not in a vertical way by profession but horizontally such as in the necessity to develop leadership skills across the organisation. One example was recognition of the need to identify and nurture the careers of high-performing women in healthcare that led to the recommendation of a strategic approach to talent which included assessing the leadership pipeline focusing on development and retention (Hauser 2014). A further outcome is the focus on complementary skills such as leader-

ship development—informing dual leadership capabilities—becoming major initiatives in American medical schools (Satiani et al. 2014: 542). The benefits of so doing were identified in a study of British NHS trusts where it was concluded that 'if having more doctors in senior decision-making roles is producing benefits then surely more emphasis needs to be placed on training to improve capabilities and on attracting and retaining talent. More could also be done to improve incentives, perhaps by rewarding contributions to leadership at the same level to those of research and academic excellence' (Veronesi et al. 2013: 153).

The definitions of talent management discussed above reflect the diversity of views about what constitutes talent, the outcomes of which lead to the products and services offered by talent management and their contribution to the achievement of organisational objectives. These are largely input-based approaches, intertwined with the continuing debate about exclusivity, inclusivity and pluralism, though there has been progress in moving towards a theoretical basis.

An alternative perspective might be to begin with the potential outputs of talent management, as seen through the lens of operational or business management and from these outputs develop talent management systems and processes able to deliver. This can be regarded as a form of 'outside in' thinking and mirrors that advocated by Ulrich and Dulebohn (2015) where the external environment and stakeholders will influence how both human resources and talent management are shaped within the organisation.

Figure 4.1 demonstrates how such a definition stems from the potential outputs of talent management and can be used to segment talented 'groups' and their associated talent management activities, and therefore a definition that takes into account these factors and the unique context of health might be the following:

> Talent management in the health sector refers to the attraction, recruitment, management, development and retention of those whose professional expertise or operational competence contributes to positive patient or societal outcomes and the creation of stakeholder value.

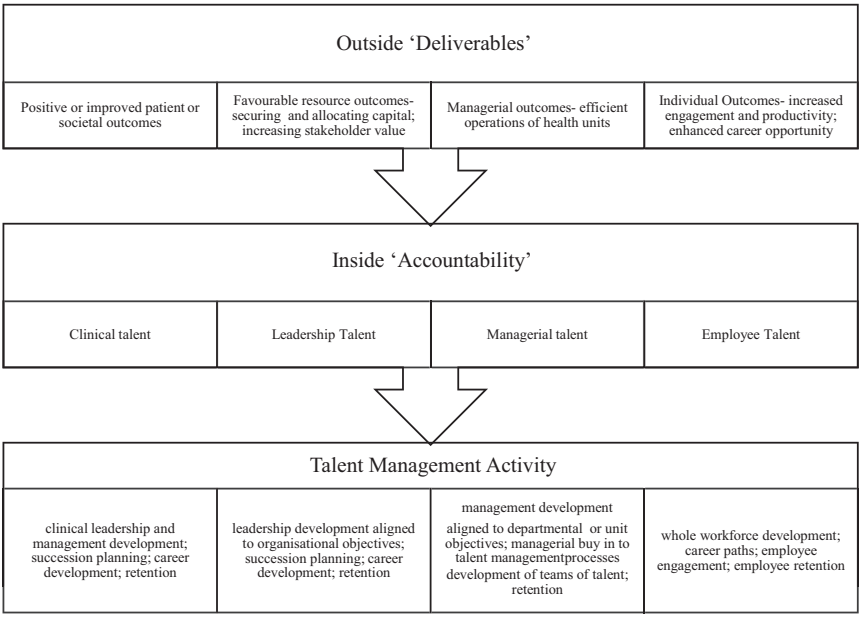

Fig. 4.1 Outside in: the outcomes of talent in the health sector and their influence on talent management definition

The complexity of the health sector environment means that others still will seek to go beyond the 'one dimensional, managerialist and unitarist approach' (Vaiman and Collings 2013: 1739) and provide talent management that takes account of multiple scenarios such as succession planning and nursing skills shortages simultaneously, for example. This contingency narrative has historically evolved out of the necessity to address immediate talent shortages, but there is evidence of an emerging strategic approach.

In all cases, health sector organisations will adopt a definition of talent relevant to their own contexts to provide a common basis and consistency for dialogue (Tansley 2011).

In the health sector, talent management is set along a continuum whose extremes are operational activities designed to fill short-term objectives or gaps in the health workforce at one extreme and a more strategic concept aligned to wider health objectives at the other.

The Application of Talent Management

Whether phenomenon- or strategy-driven or instead driven by different outside 'deliverables' as shown in Fig. 4.1, health sector organisations will be at different stages in the evolution of their talent management approaches. For some, talent management will be largely concerned with recruitment and attraction of clinical or leadership talent; for others, it will be more strategic and aligned with business goals and objectives and cross talent segments. Based on examples from each of the categories, it is possible to build a positioning model identifying four stages, in a way similar to that used by Bersin (2015) for the positioning of human resources in the organisation. The four possible stages of talent management and some of the characteristics associated with each are shown in Fig. 4.2.

In this model, those health organisations most concerned with talent management activities for senior managers, high potentials, and those in critical roles as part of a short-term talent gap or in the medium to long term as part of succession planning or those activities addressing a specific talent challenge (quantitative or qualitative) are likely to be in stages one and two and be phenomenon-driven.

However, demographic, behavioural and attitudinal forces have created a shift to a more pluralistic approach to talent management in some health organisations or to a more strategic approach and this will be reflected in stages three and four. Hence, where once approaches to talent management were framed in the context of senior managers, specialists and high potentials, theses stages increasingly embrace both exclusive and inclusive positions, often simultaneously in a pluralistic way. In addition, talent management in these stages is defined in ways that go beyond operational activity and increasingly are part of a 'strategic narrative' which includes how talent can contribute to the achievement of the organisation's objectives, how to gain executive support, the need to provide an evidence-based approach to talent management, and the balance of different priorities in different parts of the organisation into a coherent whole. In complex organisations, the approach to talent and talent management will accommodate different strategic priorities.

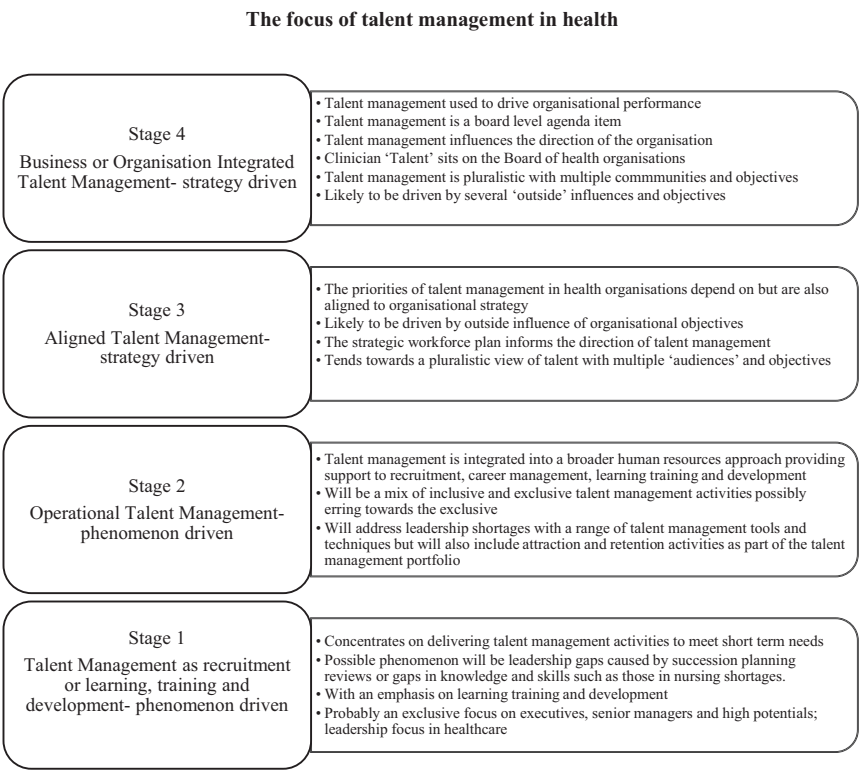

Fig. 4.2 The focus of talent management in health

This move towards a more pluralistic approach to defining talent in organisations (Thunnissen et al. 2013) has implications for talent management and how it is scoped. In stages three and four, talent management is likely to include both leadership development and whole workforce development; designing career paths for board-level successors whilst enabling the career progress of the majority of the workforce; and a range of activities to ensure that retention of talented people at all levels underpins organisational development and culture. The greater the integration of these activities with business or organisational objectives, strategies and culture, the closer the organisation will be to a stage-four organisation.

Defining talent management in the contemporary health organisation is likely to consist of a number of key components. As organisations

mature in their approach to talent management, the closer the integration and alignment of these components become. Nevertheless, the execution of effective talent management requires skilful crafting if it is to be successful, and research has shown that even though organisations recognise the importance of talent management, there are often challenges when it comes to implementation (Vaiman et al. 2012).

Whether health sector organisations choose to build bridges between the various stages of talent management outlined above will be completely dependent on their objectives for their talent management activity and the context within which this takes place.

A Heuristic Model for Executing Talent Management for Both Phenomenon- and Strategy-Driven Approaches

The execution of talent management successfully will depend on its links to the organisation's strategy, the integration of all aspects of human resources activity into a holistic process (such as recruitment and performance management), the engagement of executives and line managers in the process, and the inclusion of measures of effectiveness or organisational and individual level indicators (Fox et al. 2011).

In their 2007 study of talent management which included health sector organisations in the UK, Tansley et al. (2007) set out the processes by which talent management took place in the form of a 'talent loop' consisting of attracting, developing, managing and evaluating talent. Building on the factors included in this and incorporating later research on the component parts of talent management, a heuristic model that can be tested in the healthcare context is shown in Fig. 4.3 below. Whilst a recent study of talent management in the sector concluded that there was no clear and single definition of the talent management (Nojedeh and Ardabili 2014), attempts have been made to provide and develop talent management frameworks which would support the delivery of talent objectives. As such, the concepts of talent and talent management in organisations around the world have evolved over time. Most recently,

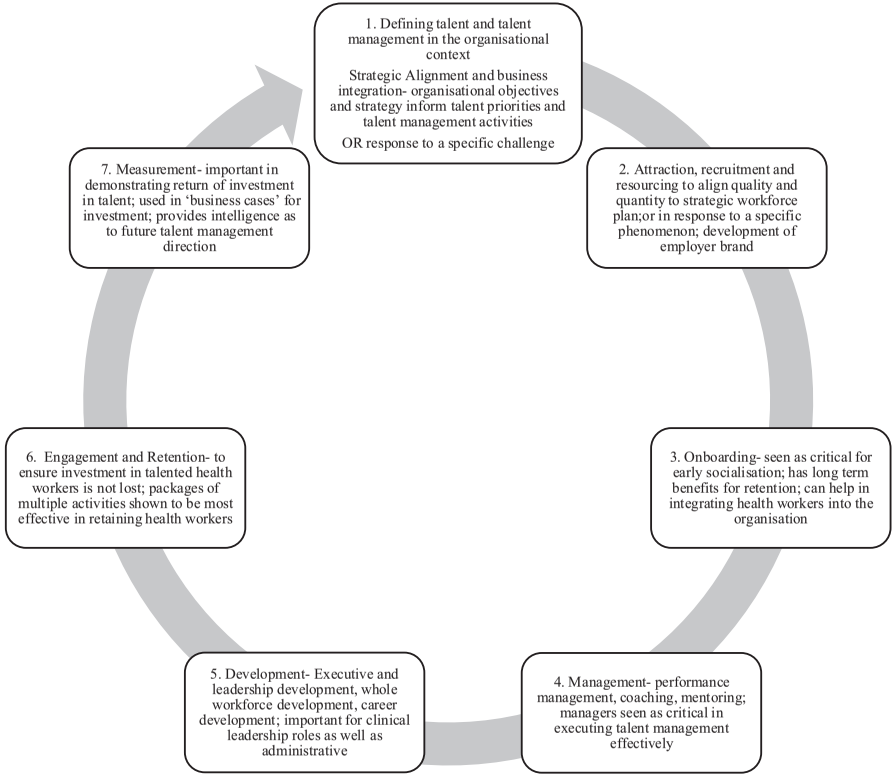

Fig. 4.3 A heuristic model of the key components of talent management in the health sector

talent management has been explained in terms of its contribution to value generation (Sparrow and Makram 2015).

Talent management therefore consists of a series of discrete yet interrelated variables aligned to the achievement of a range of organisational or individual goals. The most effective talent management is able to combine these into a workable holistic approach. The component parts of talent management and the process by which it may be delivered effectively are included in the heuristic model as shown below.

Strategic Alignment and Business or Organisation Integration

The first consideration for talent management therefore concerns the question of alignment to and integration within the organisational strategy, the development of which has been identified as a necessary requirement in a changing health environment (Porter and Lee 2015). This means a more strategic position that brings together the management of human capital with the goals and objectives of the organisation (Hejase et al. 2016). An organisational definition of talent and the constituents of talent management will be the foundations on this part of the process. And, as in exemplary healthcare organisations, there is likely to be a multi-phased approach (Groves 2011).

There is a strong basis for this since the idea that people management, which would include talent management, is critical to both individual and organisational performance was recognised in many health sector organisations in continental Europe (Frixou and Charalambous 2016), whilst the British NHS has also had a strategic focus on talent management as it sought to navigate through the complexities of its own environment. Powell et al. (2012) identified a very broad-based approach to talent in the NHS which was concerned with attracting and integrating highly skilled workers as well as developing and retaining existing health professionals. Over time, the approach to talent management has evolved to become more inclusive and it is now recognised that a systematic approach would facilitate the achievement of three workforce objectives, namely recruiting and retaining chief executives, more diverse or

inclusive leadership, and benefits in terms of organisational performance (Powell et al. 2012). However, there is also the point that the lack of clarity of definition can make implementation a challenge (Powell et al. 2013).

Strategic alignment means that talent management will be derived from the organisation's strategic objectives. These will include a mix of healthcare outcomes, performance targets and, in private healthcare, shareholder value. These factors will determine the type of organisation required, its structure and the skill sets of the people who work within it. In general, the senior management of the organisation will be responsible for setting the strategy, and research has shown that involvement in human resources development (Gubbins et al. 2005) is also essential for effective strategic integration.

Attraction, Recruitment and Resourcing

The second part of the talent management model for health concerns attracting and recruiting talent. Successful recruitment occurs where individual aspirations of employees are aligned with organisational needs (Kadam et al. 2016). Furthermore, recruitment is likely to be successful when based on multiple interventions. A recent study of recruitment in Europe (Kroezen et al. 2015) investigated a series of recruitment campaigns, including recruiting young people into healthcare in Austria and Belgium, attracting general practitioners in 'underserved areas', and attracting nurses in Finland and the Czech Republic. The good practices for recruitment included context sensitivity, depending largely on the economic or political situation at any time and the likely effect on willingness either to recruit or to join. The second was the necessity to have combinations or packages of measures in the recruitment process (not just reward factors but reward plus continuing professional development plus additional benefits). Finally, the recruitment process was more likely to have a successful outcome if it had strong executive support within the organisation.

Part of the attraction and recruitment process will also include the development of an employee value proposition and employer brand

(which is 'is the package of psychological, economic, and functional benefits that potential employees associate with employment with a particular company' (Wilden et al. 2010)). The employer brand is designed to embrace organisational values and working practices in an attempt to attract prospective employees and will be covered in more detail later. In this respect, the public sector in the UK is more likely to include working practices among their most important points of attraction whereas not-for-profit organisations are more likely to emphasise organisational values (CIPD 2016). However, there has been some caution in using employer branding in the public sector in general and in the health sector in particular. In Scandinavia, for example, a paradox was noted and 'branding in public organisations may create a spirit of unhealthy competition, prompting expenditure that is of dubious benefit … however, it can offer something of substance to help stakeholders differentiate between organisations. Brands may be both a strategic asset and a source of sustainable competitive advantage, if they make the consumer's choice process more effective, this alone could constitute a strong argument for promoting branding in the public sector' (Hytti et al. 2015). Nevertheless, in the context of tight labour markets and talent shortages, the employer brand that links values to the overall people strategy and ties these in to human resources policies for a joined-up approach will have a growing role to play in the attraction process. It is also important that the values and benefits form part of an overall employee value proposition.

Onboarding

The benefits of an effective onboarding system as part of talent management (Bauer 2010) have been recognised in healthcare organisations around the world. The high correlation between onboarding, recruitment and organisational success was identified (Hernandez and O'Connor 2010), and there are examples of onboarding as part of the socialisation process for nursing assistants in the Midwest of the USA (Henry and Escobedo 2015) and in the integration of internationally educated healthcare professionals into the Ontario, Canada, workforce (Baumann and Blythe 2009). Anderson and Garman (2014) found that formal

onboarding was a feature of both internal promotions to leadership positions in the health sector and external recruits.

The criticality of effective onboarding to the retention and engagement of talented people is supported by evidence-based practices 'that provide applicants the most comprehensive picture of the organization, such as realistic job previews and referrals by current employee selection methods that assess applicant fit with the job and organization, as well as the use of weighted application blanks, enable the hiring of individuals more likely to remain with the organization. Socialization practices that provide connections to others, positive feedback, and clear information also reduce the likelihood of turnover in the critical first year after organizational entry' (Allen et al. 2010).

Operational Management

The fourth aspect of a heuristic model for talent management in the health sector will be line or operational management both on a day-to-day basis and over the longer term, and this process has been identified as a significant contributor to the success of the talent strategy (Alfes et al. 2013; Macfarlane et al. 2012). The challenge is to do so whilst dealing with the operational pressures and expectations of health sector management from a wide range of stakeholders (patients, other stakeholders, shareholders and legislators). These factors mean that managing in the health sector is a complex and challenging task.

The numbers of managers will vary from organisation to organisation. Some will have the designated role of line manager, others will have line management as part of their clinical or technical role. Line managers make up to 5% of the workforce in formal roles in the British NHS, for example, and there are 78 categories of line manager, including clinical management, human resources management, IT and financial management (King's Fund 2010). The reality is somewhat higher because of others who don't have the 'official' title but who undertake management activity. These are the senior professionals with line management in addition to their professional responsibilities (NIHR 2013). Each of these roles will have a key part to play in the management of talent.

Managing talent has two critical components. In the first place, there will be the question of the acceptance that talent management is an important part of the overall organisational strategy (Saidi et al. 2014). Do the board and executive team 'buy in' to the concept that talent is an important part of the achievement of the organisation's goals? The second is the ability of the organisation to implement talent management successfully. Do the line managers (with whom the responsibility for implementing the bulk of activity will reside) accept their role? Are they skilled in managing talented people? Do they provide effective roles in teams or groups to ensure that talent is managed to its optimal level? Do they provide support for effective workplace learning as part of the talent management process?

Leadership, Management and Whole Workforce Development

It is recognised that leadership development is becoming critical to healthcare organisations because of the significant amount of change and transformation that are taking place in health, the necessity of having leaders able to prosper in such change, and the risks to the organisation of leaders without the necessary development to fill such important roles. Comprehensive programmes aligned to succession planning and retention of high-potential individuals are advocated (Satiani et al. 2014). Therefore, for many organisations, the prime focus of development in the talent management context is on leadership development which was aligned with the strategic goals of the organisation and linked to areas of critical development, including the identification of key leader competencies; effective job design; a focus on leadership recruitment, development and retention; leadership training and development throughout all levels of the organisation; and ongoing leadership assessment and performance management (Anderson and Garman 2014; Wells and William 2009). Though the interpretations of what elements are included in HRD continues to be the subject of debate (Hamlin and Stuart 2011).

Leadership, management and whole workforce development are therefore amongst the most important functions of talent management and the ones on which most emphasis has been placed to date. The initiation of talent management is often prompted by the need to develop an effective leadership cadre that had the skills to deal with the scope of dynamic organisations; in the USA, talent management was considered to be of strategic importance because it represented the interplay of human resource processes to build leadership capability (Pepe 2007). Furthermore, in a study of the comparison of leadership between Fortune 500 companies and healthcare organisations both showed a consensus that strong leadership was important to organisational success (Wells and Hejna 2009). In contemporary organisations, development means more than leadership development, though this is still a very important facet of talent management. Starting with board succession management and the development associated with that (often enshrined in corporate governance legislation/recommendations), the development activities within talent management will embody a range of formal and informal programmes, secondments or opportunities. In addition, the whole workforce approach in larger health organisations will require a focus on broad access to learning, training and development activities.

In the British NHS, the approach to talent management that is focused on top management and high-potential individuals is part of an evolving pluralistic approach. This is taking place increasingly in parallel with the recognition of the need to encourage and develop the potential of all members of the NHS workforce. The case for an exclusive approach is to fill the 'talent pipeline' of those with the potential to fill senior health organisation executive and management (clinical and non-clinical) positions; the case for the inclusive approach is performance-based (Birchenall and Parrish 2004; Wilson 2012). The pluralistic approach seeks to maximise the potential of executives and managers on the one hand and at the same time develop talent management to embrace a broad swathe of the health workforce. The latter is the most difficult position for talent management because it inevitable leads to tough decisions about priorities and hence investment in people.

Engagement and Retention

Talented health professionals who are engaged with their organisation's purpose and objectives, engaged with their professional vocation and engaged with the systems and processes for their own development are more likely to stay with the organisation. Hence, the importance of dealing with both subjects as part of talent management.

The challenge of retention exists in underserved regions as well as middle- and high-income countries (Carson et al. 2015; Liu et al. 2016). It is an important part of talent management because of its effect on the long-term health and success of the organisation to keep talented people in whom investment is likely to have been made. In the health sector, turnover is a serious issue that can compromise patient safety, increase healthcare costs and impact on staff morale (Dawson et al. 2014). Hence, in countries such as Slovakia, the retention of health sector staff was a prime focus because of the 'mass outflow of qualified and skilled people' (Taha et al. 2015). But this is one of the most challenging parts of the process, and a broad range of reasons for leaving have shown up in the research, including 'failure to recognize and leverage the passions of the employee; failure to challenge intellect; failure to engage creativity; failure to develop skills and failure to give the employee a voice. The variability of reasons requires a response that is multi-faceted' (Turner and Kalman 2014).

As in the attraction and recruitment process, success in retention will not come from a single intervention. Retention activities in the health sector range from medical and nursing scholarships, increases in pay (Rawal et al. 2015), and dual practice (the ability to hold multiple jobs as a way of boosting income), which has had a positive impact on health specialist intention to stay in South Africa (Ashmore and Gilson 2015). The impact of the rural pipeline (the rural pipeline means that people with 'rural origin' (who spent some childhood years in rural areas) and/or 'rural exposure' (who do part of their professional training in rural areas) has been shown to have an effect on retention in countries on the periphery of Northern Europe (Carson et al. 2015).

Measuring the Outcomes of Talent Management

A focus on performance and outcomes is at the heart of clinical practice (Walburg ed 2005) and this will also be reflected in the process of talent management. De Harlez and Malagueño's (2016) study of management control systems in hospitals provides the foundation on which the measurement of talent management can be built, though their findings suggest that a considerable amount of development will be needed to make this viable. The assumption that talent management should be aligned to the organisation's strategy carries with it the corollary that at least one set of measures should reflect the contribution of talent to the delivery of this strategy. In fact, there are multiple healthcare-specific strategic frameworks, of which four stand out—generalist, market specialist, service specialist, or superspecialist—but 'hospitals often use multiple strategies simultaneously rather than adopting a single set of stable practices focused on a sole strategy' (de Harlez and Malagueño 2016: 3). This is perhaps one of the factors that led to the discovery of a limited set of measures from their analysis of talent management in health organisations which were confined mainly to knowledge and skills improvement.

This is consistent with the whole subject of measurement of talent management, which has a checkered history. Guest's analysis (2011) highlighted six phases or 'eras' of measurement over a twenty-year period, which included linking business strategy to human resource management and using statistical analysis to demonstrate linkages between human resources practices (including those which would be embraced by the contemporary definitions of talent management) and organisational performance. Whilst the use of Kirkpatrick's valuable approach to measuring the effectiveness of training (2010) is acknowledged, there is evidence that where measurement has taken place, it is piecemeal; that is, there were no consistent approaches to the measurement of talent management effectiveness. Evaluation of the effectiveness of US executive leadership development programmes, for example, revealed that amongst the measures used were job satisfaction (66% of those responding to the research), succession planning (62%), quality improvement (62%), and patient satisfaction (58%). In addition, a large number had promotion rates,

employee satisfaction, and quality improvement as measures of executive leadership development programme effectiveness (McAlearney 2010). Future requirements will inevitably require talent management to justify the investment in it by demonstrating added value, however that is defined.

Case Study: Succession Planning in North American Health Sector Organisations

Succession planning provides a bastion against external shortages of health sector talent and comfort to those looking for solidity in internal governance. It is becoming increasingly important in the strategy setting process for North American health sector organisations.

This is because, whereas in previous decades labour was plentiful and taken for granted (Rothwell 2010), the contemporary North American labour market is characterised by scarcity in key health sector skills. Hence, to counter the incidence of talent shortages, organisations have to identify and develop high-potential candidates for critical succession roles well in advance of the need to fill such roles. In addition, succession planning seeks to satisfy stakeholders, such as boards of governance, that there is continuity of leadership, management and strategy to deliver both patient outcomes and stakeholder value should key employees leave the organisation.

In its broadest context, succession planning embraces general management roles because of the high level of turnover of executives and occupants of the 'C Suite', the rate for hospital and health system CEOs has been estimated at 20%, with an average tenure of four years (Santamour 2014); clinical roles, where there can be up to an 18% vacancy rate for physicians (Punke 2013); and health professional roles such as pharmacists, where leadership succession planning was considered to be crucial for the continuity of strategy (Ellinger et al. 2014).

However, it is in the area of nursing, nurse leaders and nurse executives on which most attention is being focused. Supply factors such as the ageing of the nursing workforce with the consequent retirement of baby boomers and a skills shortfall (Zaballero et al. 2016) have exacerbated nursing shortage concerns, leading to an emphasis on retaining knowledgeable personnel to meet health organisation needs (Carriere et al. 2009). These factors, together with the uncertainty associated with political, economic and social factors affecting healthcare delivery (Griffith 2012), have intersected with a burgeoning demand. The result is disequilibrium between demand for health and the number of nurses and nurse leaders to supply it. Succession planning has been identified as a way to address the issue and is being used

proactively to identify high-potential individuals and formally develop them to assume nurse leadership roles (Evans 2016).

But nurse succession planning is about more than finding replacements. Instead, it is a strategic process which includes the identification, development and evaluation of 'intellectual capital' to ensure leadership continuity within the organisation (Titzer and Shirey 2013). It is built on a framework of the organisation's vision and mission, and the critical skills within nursing needed to move towards these. Indeed, it has been argued that a definitive succession plan may be the difference between success and failure for nurses and health sector organisations (Stichler 2008; Laframboise 2011). For some, there is an important responsibility for nurse executives to put in place an effective succession planning programme for all nursing leadership positions (Wendler et al. 2009; Trepanier and Crenshaw 2013).

The outcomes of a successful succession planning process are improved leadership, continuity in the organisation's culture, and deeper leadership bench strength (Titzer and Shirey 2013).

Numerous studies have been undertaken to identify the key components of succession planning and its delivery for nurse leaders. In addition, nurse succession planning and the associated development activities are articulated through magnet recognition processes. Organisations such as the Ronald Reagan UCLA Medical Center and Northwestern Memorial as well as Cleveland Clinic's succession planning programme and the New York City Hospitals systems approach, are examples of how to identify and develop a pipeline of potential leaders, including nurse leaders. Some of the findings in relation to effective succession planning practices are the following:

- The importance of aligning succession planning with the leadership needs identified in the organisational strategy and, having done so, crafting a clear vision and strategic plan (Cadmus 2006; Sherrod 2006). In most cases, this activity will inform the quantitative, demand-side element of succession planning. It will identify which and how many roles in the organisation are critical to the achievement of future strategy.
- A complementary activity will be to identify the qualitative implications of strategy; that is the nature of future nursing or nurse leadership roles and the required competences, knowledge, skills attitudes and behaviours for these roles. This will generate insights as to the nature of leadership at some future date as well as create avenues and strategies for accessing potential leaders and resources for their development (Sherrod 2006; Denker et al. 2015).
- Having established quantitative and qualitative demand levels, the next stage is to identify people who are able to fill succession roles immediately or have the potential to do so in the future. This will be based on best-fit assessment processes around performance and potential in the short, medium and longer term and will provide information and insight into the strengths and gaps for leadership roles. The process includes

structured appraisal and assessment tools within performance reviews, assessment or development centres for high-potential nurse leadership candidates, and the application of the nine-box grid to provide an overall picture. The effectiveness of the assessment process will be enhanced by ensuring line manager involvement in its completion (Saver 2015).

- The outcome of this assessment activity will be a primed pipeline of competent nurses with the potential for immediate succession or those being developed to step into leadership roles at some future date (Evans 2016).
- The process of talent management will include talent review sessions; development activities from an early career stage (Griffith 2012) to prepare nurses for future roles; and retention and engagement activities to ensure they stay with the organisation.
- Finally, an ongoing means of evaluation to ensure that succession plans are reassessed and take account of the shifting tides of the health sector environment influenced by both external and internal factors. Partnerships with human resources or talent professionals are key for success in this area (Cadmus 2006).

'Effective succession planning is the heart of leadership development and an essential business strategy because it enhances the ability to achieve orderly transitions and maintain productivity levels' (Kim 2012: 14). Recognition of its importance for nurses and nurse leaders is nationwide, from multiple hospital groups to individual facilities. It is likely that talent shortages will continue to generate pressure for effective nurse leader succession planning.

Conclusion and Implications for Practice

The above narrative suggests that the definition of talent is likely to be phenomenon-driven in most health sector organisations which will take into account prevailing clinical or managerial demands; the 'business' context of the organisation; and its geographic location and talent priorities. (For example, if large outflows of health talent are a feature, then the priority will be on retaining talent as part of talent management; if the need for more clinical specialists is identified, then attraction and recruitment will be key.) Talent management is likely to contain aspects the heuristic model shown above, depending on the strength of the phenomenon.

Additional areas of importance are the engagement of the executive management team in the process (Anderson and Garman 2014;

Björkman et al. 2013) and an organisation-wide understanding and agreement about what is meant by the term talent; and the effectiveness and appropriateness of the tools used in the delivery of talent management will also have an impact (Tansley 2011; Yarnall 2011). The concept of strategy-driven talent management (Silzer and Dowell 2010) means that any talent management activity will need to be aligned with the organisation's objectives.

From the above narrative, it is possible to identify two groups of talent management activity that a health sector organisation might use to assess its own position and from which the priorities of talent management culminating in a talent strategy could be directed.

- The first is organisational acceptance of the necessity of having a systematic approach to talent management and the benefits for so doing. To achieve this will require an agreed working definition of talent and talent management, which, as we have seen, will be dependent upon the context of the organisation; clarity about what talent management is designed to achieve (that is, defined objectives and measurable outcomes); a broad understanding and acceptance of the need for talent on the part of the board and executive team; a willingness on the part of managers to deliver talent management as part of their role; and skilled and knowledgeable talent professionals who are integrated fully into the organisational practices.
- The second concerns evidence of the ability to operationalise talent management for its effective delivery, which will include well-crafted implementation plans; the availability of a wide range of tools of talent management; and talent management aligned with other human resources tools and processes such as competency frameworks and those responsible for talent management with the skills necessary to effect change throughout the organisation.

The above narrative and that of previous chapters have taken a broad view of talent and talent management covering supranational, national and unit level organisations. It was noted that a range of important and dynamic forces were shaping the way in which talent in the health sector

was defined and managed. The importance of talent as a critical success factor in health was also noted.

The value of effective talent management is far-reaching and includes not only the issues that have been discussed above in balancing the demand and supply equation derived from strategic workforce planning but also dealing with the phenomena of globalisation and the intensification of change which means that 'firms increasingly require an internal structure that fosters the genesis and application of new knowledge. If the firm's objective is to achieve continuous learning then organisational variables and managerial purpose through talent management are essential for access to superior knowledge assets' (Vivas-López et al. 2011).

The ability of an organisation to craft a talent strategy and to ensure that it is implemented effectively is critical. The following chapters therefore will concentrate on the elements of such crafting at an organisational level.

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5

The Talent Management Evolution Matrix

Talent Management in Health Is Guided by Best Fit

The success of talent management in health sector organisations will come about by a combination of a talent strategy that is recognised as important by stakeholders, the operation of talent systems and processes that are efficiently delivered, and proof of value to patient outcomes and stakeholder value by ensuring that they are effectively measured and monitored.

Precursors to these will be an understanding of a base case for talent management to answer the question of 'Where are we now?' and of objectives for talent management which answer the questions of 'Where are we going?' or 'What are we looking to achieve?' The deliverables for talent management might be assessed through the approach suggested in Fig. 4.1; the foci of talent management in health outlined in Fig. 4.2 will give an organisation an understanding of its talent priorities but also the culture of talent management that is prevalent; a process as outlined in Fig. 4.3 will give an indication of the potential activity associated with talent management. Underpinning each of these will be assumptions about where the organisation is in terms of its talent management at

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a point in time to provide a foundation on which talent strategy can be built. The talent management evolution matrix will help to develop understanding in both areas.

In the health sector, there is a range of positions in both the acceptance of talent management and its implementation which align broadly into one or more categorisations, namely 'as a new term for common HR practices …; succession planning practices; a focus on strategic, core jobs that are critical to creating competitive advantage; or more generically, as the management of talented employees' (Cascio and Boudreau 2016: 111). As outlined previously, the responses to workforce challenges were mostly phenomenon-driven along the continuum outlined by Gallardo-Gallardo et al. (2015) namely from embryonic through growth to mature; or classified by different foci of talent management. Many organisations approach talent in the health sector in the context of addressing supply and demand crises in the dynamic labour market for health workers (McPake et al. 2013) complicated by the sheer complexity and 'myriad dimensions of the health care system' (Porter and Teisberg 2006: 3).

There is further recognition of the importance of talent and talent management 'including all the human and organizational elements that are pivotal to enterprise success' (Cascio and Boudreau 2016: 103) in the global health community for their strategic as well as operational potential, leading some to focus on a transition from short-term solutions to longer-term system building (Zhao et al. 2013: 799). In this context, effective talent management can lead to competitive advantage and high performance (Srinivasan and Chandwani 2014; Taylor et al. 2015). If the obstacles to effective talent management outlined by Powell et al. (2013) can be overcome, then the goals of ensuring a supply of leaders who do the right things, managers who do things right and an engaged workforce that has the skills and capabilities to perform patient care, operational and business functions effectively are possibilities. This might be referred to as future proofing of the organisation's pool of human capital (Tatoglu et al. 2016).

The challenge facing health sector organisations is that they will need to do so in spite of the continuing debate about the meaning of talent and talent management as discussed above and covered extensively in academic literature (namely Lewis and Heckman 2006; Collings and

Mellahi 2009; Tarique and Schuler 2010; Cascio and Boudreau 2016). But prevarication about what is meant by talent and about what to include within the boundaries of talent management may not be acceptable, because of a growing expectation of the value of talent management and that those associated with delivering it will have a positive contribution to the achievement of organisational goals (Day et al. 2014; Martin 2015; Mensik and Kennedy 2016; Turner et al. 2016).

A Combination of Strategic and Operational Objectives for Talent Management

Some talent management activity will result in high-level strategic expectations (Ready and Conger 2007), in which the emphasis is to develop executives and high potentials (in order to provide replacements to key or succession positions), to attract high-quality graduates, and to deliver management and leadership development. There is a particular focus in this area in, for example, improving the identification and training of future public health leaders (Day et al. 2014: 558); talent mapping, succession planning, and talent managing processes to prepare the nurse leaders of tomorrow (Mensik and Kennedy 2016: 133); and the development of strategic management skills for health sector leaders (Kumar et al. 2014). In the British National Health Service, a particular expectation of talent management was the production of future leaders through the aspiring chief executives and aspiring directors programmes. In the longer term, it was anticipated that there would be an increased leadership supply, including clinical leaders 'and with leaders reflecting the workforce and the communities they serve' (Powell et al. 2013: 294).

Where there is a more inclusive, pluralistic, or whole workforce approach, talent management will have a broader definition and will include an emphasis on careers, career paths and the training necessary to achieve them for the majority of the workforce. In addition, there will be an emphasis on cultural alignment, employee engagement and reward as part of an employee value proposition that attracts and retains talented people wherever they sit in the organisation. The inclusive 'talent tree' concept in China with a multi-layered definition of talent at the

'base-trunk-crown' of a tree gave the opportunity for individualised training and development (Yi et al. 2015); in the USA, talent management included mentoring opportunities to earn credentials and certification with a view to attract and retain in a range of clinical roles (Taylor 2004); and the creation of talent pools as part of strategic staffing (Rodrigues 2015) was expected to deliver productivity, efficiency and operational flexibility.

In all cases, for the health sector organisation to achieve its talent objectives, a definition of talent *in that organisation*, identification of activities and resources associated with talent management *in that organisation* and a sense that these are aligned to immediate or longer-term objectives of the organisation will be expected. In each context, talent management is guided by best fit (Budhwar et al. 2016) rather than best practice.

The question to be addressed is how can an organisation in the health sector establish a base position from which to undertake further development in a way that maximises the return on the level of investment needed? A possible model will include an identification of strengths and weaknesses in the existing approach and use this 'evidence' to make informed decisions about priorities and resource allocation for a talent strategy 'in order to fully capitalize on the potential of employees healthcare organizations should focus their attention on developing more strategic approach' to talented employees (Ingram and Glod 2016: 345).

Contemporary Methods for Assessing the Current Talent Position

The attempt to make explicit the ties between strategy and talent (Lewis and Heckman 2006: 144) has resulted in strategic positioning models, including high-level talent reviews (annual or biannual); operational models, which will be tied in with the overall performance review process; and metrics such as analysis of training expenditure/number of training days per employee and number of career moves or promotions. Most large organisations will have some element of talent review as part of their annual reporting process.

Organisations in the health sector use a variety of methodologies for assessing the current talent position, from one of concentrating on positions rather than 'the identification of talents' (Ingram and Glod 2016: 344) to a talent review (Powell et al. 2013) which would identify key areas of strength and opportunity in talent that the organisation already has in place and from these devise appropriate talent strategies. Talent mapping, which 'is the process of comparing existing talent with future needs' (Mensik and Kennedy 2016), has been applied to the Nurse Leadership challenge in the USA. Other methods include the concept of inherent talent and strengths, competency assessment tools, and processes associated with human capital or workforce planning (Thompson and Ahrens 2015; Martin 2015; Zhang et al. 2015).

For some, the identification of key people and how to maximise their performance and potential over the long and short term will form the basis of the review. Figure 5.1 is an adaptation of the familiar '9 Box Grid' (attributed to Odiome 1984; see Sparrow and Makram 2015) which is used in this process. For others, the approach is the 'identification of key positions rather than talented individuals per se' (Collings and Mellahi 2009: 304). A combination of the two would result in a better understanding of the 'bench strength in all of its positions within the company, both anticipated and unanticipated, in all current and future locations around the world' (Tarique and Schuler 2010: 129). This human capital approach to talent management (Nijs et al. 2014: 181) will provide the legitimisation of investment in identified employees or jobs.

On the grid at Fig. 5.1, the axes of performance and potential and the nomenclature within the framework will be set by the needs of individual organisations. In the absence of any consistent theoretical basis for talent management, the criteria for where a person sits in the matrix will be organisation-specific or the result of benchmarking with other organisations (in a broad range of human resource (HR) practices—for example, in Canada (Shaw 2015)—or for specific talent programmes (Church et al. 2015)). The traditional talent review will look to place some or all of the workforce within this framework, and from the subsequent analysis, a picture of current positioning can be created. A surfeit or deficit in any of the nine boxes and the direction of travel of those within the boxes (quality and quantity) will be important data in deriving

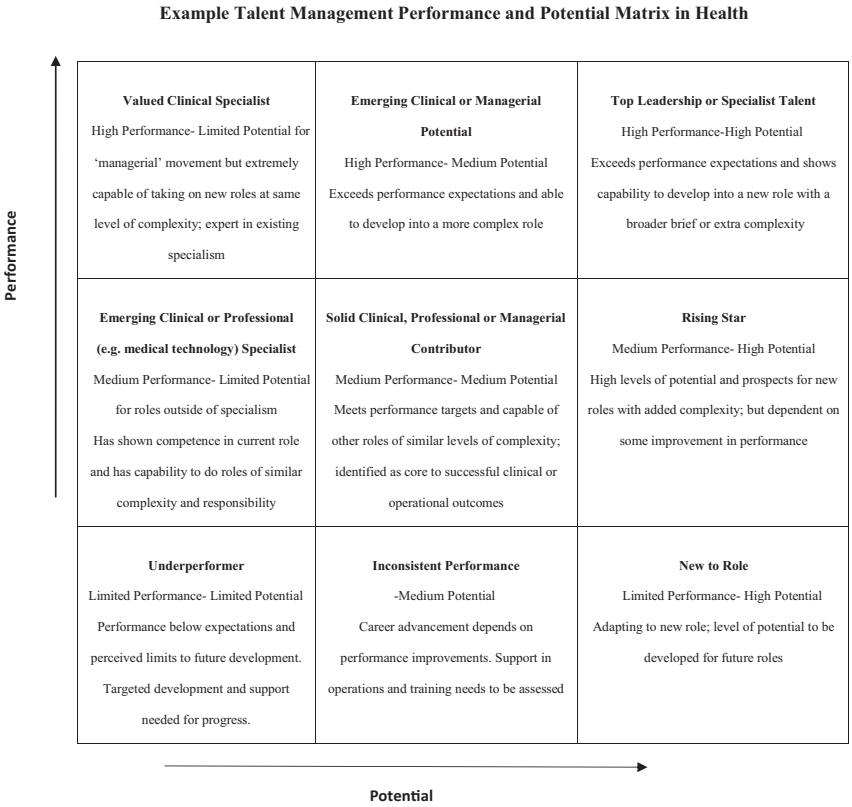

Fig. 5.1 Example of talent management performance and potential matrix in health

subsequent talent strategies. The key to the successful application of this model is the alignment with the organisation's overall objectives within its own unique context. Nevertheless, in spite of its ubiquity, the model has also been subject to criticism.

The allocation of a 'score' or 'position' against performance (for example, through forced distribution) can lead to improved short-term task performance because it can motivate as well as help to attract and retain top talent, but it has a downside because it may also lead to what Moon et al. (2016) refer to as lower citizenship performance through perceptions of injustice. Furthermore, the identification of high potentials through such processes can lead to varying, not always positive, reactions

of employees with particular respect to organisational justice. Research has shown that categorising an employee as high potential can lead to different perceptions about distributive justice, although effective interventions can mitigate the effects of this (Gelens et al. 2014). In spite of these criticisms, the 'nine box grid' has endured.

This narrative outlines a rich array of methodologies for assessing the position in terms of talent management, ranging from strategic human capital approaches tied in to a macro level workforce plan or more operational phenomenon-driven approaches based on the need to fulfil short-term objectives. Talent management in the health sector is based on best fit, and the question is how to ensure that it can evolve into a sustainable value-adding process.

To this end, a 'talent management evolution matrix' as shown in Fig. 5.2 is a means of assessing organisational positioning. To determine where an organisation is in respect to this scale will require two things. In the first

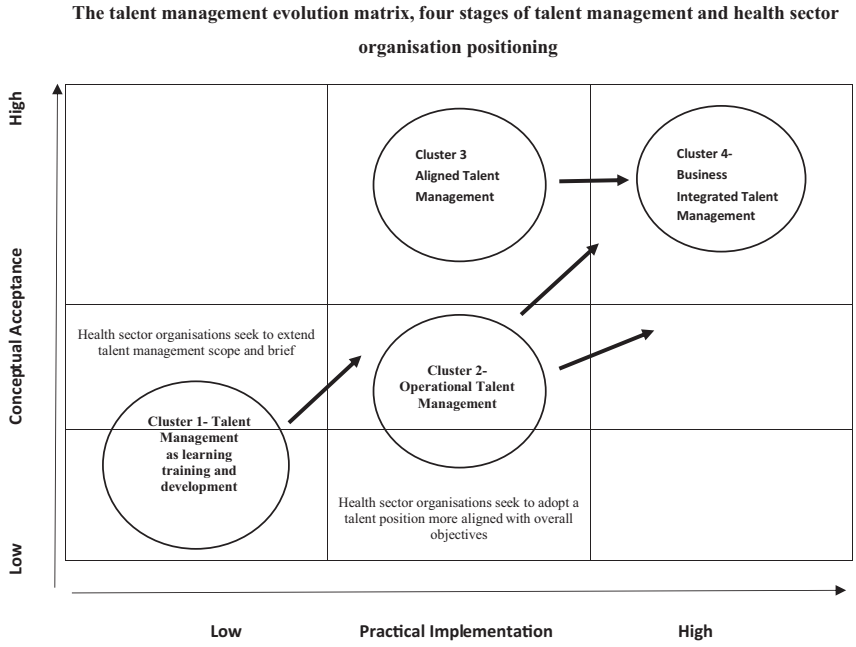

Fig. 5.2 The talent management evolution matrix, four stages of talent management and health sector organisation positioning

place, there will be evidence produced by talent professionals, including activities already undertaken and any measures that might be relevant such as returns on investment through training and development activity or numbers of people going through programmes. Secondly, there will be a dialogue between talent and HR professionals and the executives and managers of the organisation to establish a consistent view of the positioning of talent management.

Organisation-wide agreement to positioning on the matrix will provide a foundation on which future talent strategy can be developed and resources allocated appropriately and efficiently.

The Constructs of the Talent Management Evolution Matrix and Its Application to the Health Sector

The principles of talent management (Collings and Mellahi 2009; Tarique and Schuler 2010; Stahl et al. 2011; Gallardo-Gallardo et al. 2015; Cascio and Boudreau 2016; Ingram and Glod 2016), the role of the executive team and the implementation of talent (Yarnall 2011; Scott-Ladd et al. 2010; Lo and Fu 2016), measuring effectiveness (Yapp 2009), and strategy-driven talent management (Lewis and Heckman 2006; Lockwood 2006; Silzer and Dowell 2010) suggest that two groups of criteria affect the success of talent management in an organisation.

In the first, the level of organisational **conceptual acceptance** with respect to the role and value of talent management will influence the amount of resources allocated, the scope of what or who is included within its boundaries, and an interpretation of the benefits of talent management. In the second, the ability to craft talent management so that it delivers its stated outcomes will be important through effective **practical implementation.** These two form the axes of the talent management evolution matrix shown in Fig. 5.2, and assessment against each will give an indication of the location of the organisation in its talent management development.

Key Indicators of Conceptual Acceptance of Talent Management in the Health Sector

The scope of conceptual acceptance covers the depth of the organisation, from the board or executive team, setting the direction for talent management and facilitating the allocation of resources, to line managers whose role will be critical to the execution of subsequent talent strategies and a workforce motivated to participate in talent systems and processes. The components of this aspect of the matrix are as follows.

A Clear Definition of Talent and Talent Management

Health sector organisations have created a rich vein of talent definitions based on contextual best fit as outlined in earlier chapters. These are dependent on the nature of the organisation and its maturity in dealing with talent and talent management, its priorities and the state of the labour market (Meyers and van Woerkom 2014). Talent is largely phenomenon-driven (Thunnissen et al. 2013), which means that, for example, a health sector organisation that has a challenge recruiting clinical specialists will have that subject as the focus of its talent strategy and talent management activities will be designed to meet this, whereas an organisation that has problems in retaining key nursing staff will have a different focus and talent management processes.

There are examples in North America, Asia, Africa and Europe of an approach which recognises the need for a leadership pipeline and hence investment in development but also the need to develop the talents of the whole workforce (Yeoh and Eng 2008; Grant and Kronstal 2010; Wilson 2012; Taha et al. 2015; Nafei 2015). Clarity of the definition of talent is actively sought as a foundation on which to build a talent strategy or to develop talent management tools and techniques to support the organisations in their drive towards achieving their objectives.

The Support of the Board and Executive Team and Strategic Alignment

Talent management stands a greater chance of sustained success if it is aligned to the achievement of the organisation's strategy and has the active support of the board or executive team or both. Indeed, it is argued that there is an awareness amongst corporate leaders that talent management is imperative to organisational effectiveness but that it is a difficult task to deliver for both executives and HR professionals. If talent is used to develop a strategic as well as operational position, this will create a significant amount of conceptual acceptance at the board level. Scullion and Collings's (2011) study of global talent management found that some 70% of leaders in researched organisations spent 20% of the time on talent management but that 90% of CEOs saw talent as one of their strategic priorities. Additional work by the authors reinforced the criticality of the strategic perspective (Scullion et al. 2010). It is this type of consideration that would rate highly on the talent management evolution matrix. Research by Huselid and others (1997, 2011) has reflected the possibilities for talent as a strategic entity contributing not only to alignment (Evolutionary change) but possibly to shaping the very direction of the organisation (Revolutionary change.) In the health sector, the links between improved organisational performance and organisational learning and growth will be strengthened through a strategic alignment of talent with the organisation's goals and objectives (Shukri and Ramli 2015).

A Recognised 'Business Case' for Investment

Creating a more empirical approach to all aspects of HR management (HRM) was considered an important step in forging the relationship between HR practice and improved organisational performance. However, there is still work to do, and even 'after hundreds of research studies we are still in no position to assert with any confidence that good HRM has an impact on organisation performance' (Guest 2011: 11). A business case for investment in talent means showing that it will produce

a return as demonstrated through either strategic or operational performance or impact on the individuals involved (better retention; more engagement). Several types of return have been identified in recent studies, including 'converting data to money', measuring causality and relationships such as that between whole workforce development and increased employee engagement, and those concerning return on investment which can be impact of activity or forecasting the impact of activity (Phillips et al. 2016).

The business case therefore will consist of a series of 'tangible' outcomes such as enhancing performance or increased profitability, improvements in patient and workforce satisfaction, improvements in the delivery of new services to the healthcare market by having talented people in developing them, or improvements in the value of intangible assets (which could make up as much as 80% of an organisation's worth) such as goodwill, patents and licenses, trademarks, trade names, intellectual capital and corporate reputation. The impact of investment in talent in health will be enhanced by more comprehensive and reliable data which will be used to prepare evidence to inform health workforce planning and management (Cometto and Campbell 2016). The preparation of a business case will be a step closer to this objective.

Line Managers Who Are Willing and Have the Capability to Implement Talent Management

The success of the talent strategy is dependent on and directly related to the success of line managers implementing the tools and processes of talent management (Alfes et al. 2013; Macfarlane et al. 2012). In the health sector, this role has to fit in with day-to-day pressures caused by rising patient and public expectations, financial stringency and resourcing. However, it is becoming an inherent part of the role because many aspects of talent management are best handled by 'day-to-day' managers (Cappelli 2013). As shaper of the departmental or unit culture, the line manager will have a large role to play in employee outlook on career and development opportunities, the ability to participate in developmental projects, the willingness to facilitate moves outside of the department

or unit, and overall the creation of a culture in which people are seen as having talent irrespective of where they sit in the hierarchy or network. Furthermore, the line manager is increasingly a 'talent spotter' (Hirsh 2015), identifying people with the potential to undertake other roles either within or outside of the manager's department. In the health sector, managers who recognise the need to adapt their working processes to ensure that talented clinical staff are motivated to stay with the organisation (Kaliannan et al. 2016); line managers who give support and coaching to nurses resulted in strong and positive affective commitment (Ruiller and Van Der Heijden 2016) reflect this line manager engagement with talent management.

The line manager's conceptual acceptance of the importance of the subject, commitment to implementing any organisational tools or processes, and willingness to spot talent for the benefit of the whole organisation will contribute significantly to high rating for conceptual acceptance on the talent management evolution matrix.

Skilled and Knowledgeable Talent Professionals

Whilst the value of HR for health has been recognised and is growing in importance, there is still work to be done in highlighting and identifying critical success factors for HR and talent professionals. This might take place two levels (Hassani et al. 2013). In the first, deemed to be an instrumental approach, HR professionals provided knowledge and assistance to the organisation through transactions on such issues as the ethical recruitment of health workers from other jurisdictions (Bourgeault 2013), recruitment and selection, compensation and reward, and performance appraisal, which when effective were found to play an important role in the unit's capability (Syed and Sengottuvel 2016). The second role is to shape the organisation's human systems and processes such that HRM becomes 'a systematic and systemic process involving all subsystems of the whole health care system … HRM is an inseparable subsystem of the health system without which the whole system wouldn't be able to deliver the right services' (Hassani et al. 2013: 60) and that talent management forms part of this process.

The scope and remit of talent professionals in health sector organisations will determine their involvement at a phenomenon or strategic level. As talent management has evolved from an operational function to a strategic one, which Turner and Kalman (2014) refer to as Talent 4.0, a new set of competencies is also necessary for those involved in talent management. Ulrich et al.'s (2012) identification of new HR competencies to include being a strategic positioner and capability builder could equally be reflected in the roles of talent professionals. How such roles are effected will determine the position in the conceptual acceptance axis of the talent management evolution matrix.

A Workforce That Is Active in Talent Management Tools and Processes

The readiness of talent and talent agility both have been identified as critical success factors for organisational development and growth in the changing environment for healthcare (Martin 2015). To achieve this will require not only the availability of the tools and techniques for talent management but an active workforce that believes in their efficacy and has the knowledge and skills to use the tools (different from the knowledge and skills to the job) and a commitment to performing to the highest level. This will require integrated talent activities that are 'embedded in the employee experience' (Garr 2016: 26).

The tools of talent management in this case can vary from defined career paths and support for nurses to career coaching and support for medical staff looking to move into management roles, from the provision of online learning and training programmes to executive leadership development, or the willingness to take on new roles or projects. In this respect, training tools can be either formal (programmes and secondments) or informal at the place of work through coaching or line manager mentoring. Demonstrations of active, agile and flexible workforces that respond to identified talent needs are present in the health sector (Srinivasan and Chandwani 2014).

Key Indicators of the Practical Implementation of Talent Management in an Organisation

For talent management to move from being a concept to being integrated into the systems and processes of the health unit or group of units will require a specific focus and skill in implementation. The quality of these skills will be the difference between successful talent management and the failure to convert the promise to reality. The second aspect of the talent management evolution matrix therefore concentrates on how talent management is operationalised, how practical implementation leads to the delivery of desired outcomes.

Well-Crafted Implementation Plans

The phenomenological nature of talent management doesn't preclude the need for well-thought-through implementation plans. In the health sector, these mean talent management programmes that are responsive to the needs of organisation and that are tied in with strategic workforce plans, reflecting the competencies and skills for current and future objectives and include measures of performance. The provision of 'tools, resources, training, and development opportunities' will ensure that health employees (at all levels) have the necessary skills to fulfil their roles (Douglas 2013). However, as with other high-performance work practices in the health sector, there is likely to be variability caused by both 'macro-organizational (strategic level) and micro-organizational (individual level) reasons'. The variability is about the context of the organisation and therefore the implementation plans for talent management will have to be crafted according to the unique position of the health organisation in question.

The Availability of the Tools of Talent Management

The availability of the tools of talent management to executives, managers and the workforce as a whole is a prime determinant of how a health sector organisation can position itself on the matrix. There are

examples of both the recognition of the value of the range of talent management tools and their application in health sector organisations which are broad-ranging, such as the management of the transition process of novice nurses (Yee et al. 2015) to the Pathway to Excellence and Magnet programmes in the USA designed to create professional practice environments with career development opportunities (Pabico and Cadmus 2016). The challenges of US healthcare reform and the challenges of achieving the triple-care objectives of improving the patient care experience, decreasing per-person costs, and improving the health of the population created the need for strong leadership, particularly from physicians and so 'to address the gap in physician leadership skills, many healthcare organizations have created leadership development programs (LDPs) specifically targeting physicians' (Throgmorton et al. 2016). A study of health programme performance in low- and middle-income countries showed that innovative applications of recruitment, new reward and training processes enhanced the level of services that could be provided (and reduced attrition) (Bhattacharyya et al. 2015).

Talent Management Aligned to Other HR Processes Such as Competency Frameworks

There is a positive relationship between talent management activities, recruitment, retention and training in broad management skills with high performance in hospitals and indeed where these links are weak or absent it may lead to lower levels of performance (Agarwal et al. 2016). Research into medical leadership programmes showed positive outcomes where there was a combination of workplace-based projects, orientation placements and learning episodes from targeted leadership activities; workplace-based projects offered opportunities to work with senior clinicians and managers; trainees benefitted from the leadership expertise and experience they encountered; and orientation placements facilitated access to a variety of healthcare organisations (Agius et al. 2015). Hence, the alignment of talent management activities with other HR processes in an integrated and 'joined up' way will create a stronger proposition than individual initiatives per se.

Line Managers with the Skills Necessary to Implement Talent Management and the Incentive to Do So

Line managers will be critical to the success of talent management. As part of conceptual acceptance, they will be engaged with the processes in an intellectual way, seeing benefits to their own departments or units. However, there will also be the need to integrate talent management into day-to-day activity which can present challenges. The diversity of line management activities—grouped into three categories of 'operational', 'people' and 'talent'—means that the processes of talent management will be only one of a series of important activities which will contribute to whether a line manager achieves his or her activities. Two factors will have an impact on the importance given to talent management. The first concerns the skills necessary to deliver talent management in an optimum way. The second concerns the incentive to do so. Both can be covered by modifications to the performance management process and this will be covered in more detail in later chapters.

Talent Professionals with Strong Change Management Skills

The final aspect of practical implementation relates to the knowledge, skills attitudes and behaviours of talent professionals tasked with the goal of introducing talent management into the organisation or developing it further where it is already in place. The creation of a business case and strategic alignment to the organisation's goals will not, by itself, be sufficient to ensure effective implementation of talent management. In addition to these and other processes, talent management professionals, or HR professionals with talent management responsibilities, will also require change skills to deliver. Becoming a change champion is one of the new domains for people professionals proposed by Ulrich et al. (2012) and the skills to do so will be a critical factor in the success of talent professionals in delivering processes to the organisation.

Case Study: Talent Development in the American Healthcare System: Meeting the Demands of the Unknowable Future

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An Era of Transformation and Change

The American Healthcare system has seen drastic changes in recent years. At its centre is the evolution in the regulation, policies and procedures by which care is delivered to patients. In addition to major changes in policies, the inception of new technologies and payment models has caused a major stir not only among the clinicians who deliver the care but for those who support this function, especially within talent development. Lastly, the generational shift within the workforce, particularly in healthcare, is a key focus area for healthcare talent developers. As the age profile of the healthcare workforce begins to get younger, the approach to learning and talent development must be mindful of the differences in how learning is absorbed and preferred by this multi-generational workforce.

To keep up with these changes, a steady progression in talent development tactics and strategies is required. Although customer satisfaction and patient experience have been the name of the game in recent years, the nuances brought forth by the changing landscape have shifted the focus of the healthcare talent development industry to more introspective topics such as employee motivation, engagement, and more innovative and experiential learning methodologies. In the coming years, the challenges will include adopting new talent management practices, implementing non-traditional recruitment strategies, and developing employees. These areas will continue to be the focus for years to come, and healthcare organisations will have to step up their game to meet the challenging demands of the unknowable future.

Aligning Talent to Organisational Goals

In healthcare, the academic part of learning is only a preliminary step; it involves obtaining knowledge via textbooks, classroom, labs, and clinic. As healthcare continues to evolve, it has become evident that more is required in order for healthcare professionals to effectively deliver care at the highest levels. In addition to academic studies, the development of internal learning programmes among healthcare employers has risen in recent years. Many of these programmes place a focus on job training and experiential learning. Through this approach, knowledge is measured through performance in the workplace versus through tests in the academic world. The biggest difference between the two methods is that the academic approach will have the outcome of a passing (or failing) grade whereas the workplace approach results in goal attainment (or not). This method requires talent development professionals to integrate training programmes with corporate outcomes and goals and ensure that participants

apply what they learned and use their skills in the workplace to meet those aims. Although this concept is not a new thing, many healthcare organisations have turned to this approach in order to save money. By leveraging the internal experts who reside within one's institution, the talent development team is able to keep costs low while ensuring that institutional knowledge continues to be imparted.

Technology and Talent Development

The use of technology in healthcare talent development is also considered key to achieving a safe and sustainable person-centred healthcare environment for all individuals. It has the potential to reduce disintegration of waste, lower costs, and improve the safety and satisfaction of the patient experience. In 2016, technology played a huge role in the learning process at healthcare organisations; the use of apps, online courses, and games have become common techniques to facilitate and personalise learning for employees. Aside from the learning process, numerous apps were developed to improve the patient experience and facilitate the work of many industry professionals.

So what does this mean for healthcare trainers and talent developers? It means that technology is here to stay and that it evolves at the drop of a hat. And while talent development professionals need to maintain their nimbleness and ability as this technology changes, there is a true opportunity here to redefine the learning culture within organisations for the better; learning resources and opportunities are accessible more than they have ever been. As Association for Talent Development authors David Grebow and Stephen Gill noted in their 2016 webinar presentation, "it is the job of leaders and talent developers to help people understand what learning is out there and how it should be delivered and prioritized". Grebow and Gill went on to say that the rise in technology is a catalyst for organisations to redefine their cultures of learning: "technology helps organizations scale their learning across the board thus allowing learners to pull the information they need rather than the traditional push learning methods". According to Gill, having the right combination of push and pull provides the optimal learning environment.

A Generational Workforce Shift

Today's workforce is grappling with a workforce shift as baby boomers retire and millennials begin to step into their shoes. Within the healthcare industry in particular, the challenges brought about by this shift are likely to be exacerbated by an increase in demand for services as a consequence of the ageing baby boomers. Healthcare will experience a brain drain as its most experienced clinicians are replaced with those with less experience. Millennials are now the largest living US generation. Yet what drives them and how they view success are very different from previous generations. Gallup research has defined the "Big Six" to help employers better understand what differentiates this generation from older ones.

According to Gallup, millennials:

- don't just work for a pay check; they want a purpose.
- are not pursuing job satisfaction; they are pursuing development.
- prefer coaches over bosses.
- don't want annual reviews; they want ongoing conversations.
- would rather focus on developing their strengths than fixing their weaknesses.
- don't want employment that is just a job; it should be a life as well.

Evidence-Based Healthcare Responses

Moreover, the US healthcare industry is again at the centre of revision and transformation and therefore the talent development profession. That said, to survive the legislative changes and policy challenges the new government will impose, it's important to stay on top of inevitable policy changes and reimbursement trends. Healthcare leaders also need to be aware of the latest consumerism and consolidation trends as they will continue to change course. Healthcare experts weigh in on what to watch for the year with new legislators deploys.

Introducing more evidence into the healthcare system—from business intelligence to measuring quality care to rework the reimbursement system—has complicated political and regulatory implications.

The end goal is to be prepared for big policy changes forecasting what may be coming and planning how it could affect the organisation and its key stakeholders. Although right now there is no certitude about the outline of legislation, there are projects from conservative groups that could be the groundwork for a new policy.

The bottom line for healthcare managers to align with the government needs would be creating higher value at lower costs. The formula to get there is simple: value equals quality over price. Everyday collaboration with clinicians and executives who are focused on delivering better results for their patients and decreasing the overall cost of care will make this possible. Along with a team of experts, the healthcare management will learn how to track performance with analytics applications and business intelligence. Then the top management can wisecrack into the data to discover the correlation between clinical results and cost. With this approach, both providers and administrators can see how creating higher value contributes to significant performance and growth improvements. But we need to speed up the development process and ensure that healthcare as a whole can achieve the types of growth possible by digging deep into untapped data sources.

Business intelligence may not sound like something that belongs in a healthcare setting. After all, what role can it possibly play in medical excellence and compassionate care? But federal mandates that require cost and

care improvement and reporting on those development metrics are driving the need for business intelligence tools. For healthcare management, this means an enterprise data warehouse with the processing power and architecture to handle the vast volumes of data, analytics applications that will effectively unlock the data, and data visualisation tools to quickly illustrate areas of opportunity.

The key talent management approach to deal with policy changes would be continual process improvement and high performance, developing talent in areas of business intelligence that will determine the return on investment.

Clusters of Organisations in the Talent Management Evolution Matrix

A combination of position in the talent management evolution matrix and the stage at which an organisation finds itself can be used to support decision making in the direction of travel of talent strategy and talent management. Research in health sector organisations together with evaluation from secondary sources has been used to evaluate common positions on the matrix, and from this four broad positional clusters have been identified. The findings and conclusions with respect to each of these are discussed below.

Cluster 1: Low Conceptual Acceptance—Some Practical Implementation

Cluster 1 contains those organisations in the health sector that are at the early stages in the process of talent management. They are characterised by having some talent management in place, such as leadership development or intern programmes, in response to a specific challenge or set of challenges. There is recognition on the part of senior managers for investment in such activities to deal with the specific set of circumstances, but there is no perceived conceptual "buy in" to a longer-term commitment. In this case, the direction of the organisation would be to embrace talent management as a critical business activity based on understanding the benefits of so doing, to integrate talent management into the role of

the line manager, and to develop a set of talent management tools that could be used to maximise the talent of those in the organisation. Those tools could range from the development of career paths, having career guidance, mentoring schemes, and a range of training and development opportunities for the whole workforce as well as structured succession management, leadership development, strategic secondments, and executive coaching for the executives within the organisation. In parallel, the profile of talent as a critical success factor would be raised within the organisation and an engagement process for managers and the workforce would be instigated.

Cluster 2: Relatively Low Conceptual Acceptance, a Relatively High Level of Practical Implementation

The second cluster of health sector organisations consisted of those that had implemented a range of talent management activities driven by HR practice rather than strategic alignment. In these organisations, the range of talent management activities would be relatively extensive though focused mainly on the leadership, management and high-potential group. If executive or clinical succession plans had shown gaps in future leadership, then this would have prompted action in the form of leadership development or strategic recruitment; if there had been a dearth of line management skills identified through a training needs analysis, then this would also have precipitated the implementation of management development programmes. Finally, organisational change or transformation, a feature of many health sector organisations, would itself have required new skills and attitudes, and talent management processes would be the response.

Organisations surveyed in the health sector were in different evolutionary stages that could be included in clusters 1 and 2. They had taken positive steps towards the development of talent management systems and processes and were crafting their approaches in accordance with the prevailing forces in their own organisations responding to talent shortages on the one hand whilst developing a more holistic approach to talent management on the other.

Cluster 3: A High Level of Conceptual Acceptance, Medium Practical Implementation

The third group of organisations were those that had fully embraced the concept of talent management, possibly at the instigation of the chief executive or other members of the executive team and were active in delivering talent management tools and processes. In this case, the groundswell of positivity towards talent was ahead of the curve of delivery. It is likely that leadership development and the associated tools at this level, such as coaching or secondment, were in place and that this was at a mature stage. Furthermore, there was a possibility that talent was a board-level agenda item (through an annual talent review) with executives participating in both talent identification and resourcing decisions. As organisations matured in this, the concept of talent management could be stretched to cover new segments of the workforce (clinical specialists, high potentials, or graduate administrators) and a wider range of talent tools and processes could be offered.

Cluster 4: High Levels of Conceptual Acceptance and Practical Implementation

Some health sector organisations have a sophisticated approach to talent management that was fully integrated into 'business' or organisational objectives. In these organisations, talent was a board-level agenda item and talent management went beyond the annual talent review. These organisations had a whole workforce approach to talent management incorporating the features of pluralism and providing career development and training for the majority of employees and at the same time ensuring that there was a supply of those in organisational or clinical leadership positions. In addition, recognition of unique talents or talent-driven business performance attributes contributed to the development of strategy rather than responding to the needs of strategy. In this cluster, an agreed, organisation-wide definition of talent and talent management was complemented by a consistent language of talent and a proactive, strategic approach to talent management which was seen to offer organisational

benefits. Talent professionals acted as both strategic positioners and capability builders (Ulrich et al. 2012).

The talent management evolution matrix was intended to facilitate the development of talent strategy within organisations. It acknowledges that organisations will be at different stages in their development and that understanding the base point would enable directional and resourcing decisions to be made. Best fit is the initial driver with best practice as the longer-term objective.

Conclusion and Implications for Practice

Definitional clarity about what is meant by talent and how this translates into health sector organisation strategy can be brought together into the talent management evolution matrix to identify an organisation's position in terms of its maturity in talent management. There is no ideal position and the matrix is not intended to be a league table. Instead, it is intended to give organisations a perceived and relative position from which they could develop talent strategy.

On the assumption that talent management is likely to be based on best fit rather than best practice, the understanding brought about by this positioning could be of critical importance. It will help to determine not only the strategic direction in which talent management should go, and the level of resources needed, but in its most advanced form could also contribute to the direction of the whole organisation. This is based on the assumption that talent is in short supply, that talent can help an organisation to deliver its objectives and that talent can be used to develop new models or modes of operation.

There are implications for the practice of health sector organisations:

- Research has shown a correlation between organisations which have a reputation for talent management (reflected in the employer brand) and the involvement of the CEO in talent and talent management (Brown and Turner 2008). Where support for talent management flowed from those at the top and cascaded throughout the rest of the organisation, the chances of successfully implementing talent

management increase. Therefore, from a practice perspective, the role of the most senior people (administrative or clinical) will have an impact on talent management.

- A process by which this could be achieved would be board-level dialogue necessary to establish strategic value of having structured talent management.
- The evidential foundation for this would be the perceived 'as is' position as shown on the talent management evolution matrix, the dialogue in developing which will give clarity to the importance with which the organisation views talent, a range of possibilities as to the direction and an indication of talent priorities.
- In addition, it will provide the basis for resourcing discussions with respect to talent and to where priority should be given, in which places (units, departments), to which people and over what period of time.
- Finally, the dialogue necessary to develop a perceived position and the strategic options in developing from that position would also be enhanced by engaging line managers from an early stage is critical to ensure they are committed to the subsequent organisational approaches to talent management.

The previous chapters have highlighted some of the challenges facing health sector organisations as they develop the approaches to talent and talent management. The conclusion was that in the health sector the definition of talent was likely to be based on an organisation's own unique context; that it would be best fit rather than best practice; that the approach to talent management would be determined by organisational priorities, whether they be short- or long-term; and that there would likely be some difference between conceptual acceptance and practical implementation between organisations.

Regardless of the position in the talent management evolution matrix, health sector organisations have choices to make in terms of how they allocate often scarce resources between competing projects. The development of a talent strategy will be a valuable contribution to these decisions, and the following chapter investigates the experiences and practices of those health sector organisations that are at this stage in their evolution.

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6

Talent Strategy: Alignment and Integration

A Strategic Narrative for Talent in Health Sector Organisations

The talent management evolution matrix identified the perceived existing position of a health sector organisation with respect to both conceptual acceptance of talent and the practical implementation of talent management systems and processes. Alignment with the organisation's objectives and the talent implications of this indicate a state to which the organisation aspires. The creation of a talent strategy is a way to bridge the gap between the two positions in both the short-term (mostly phenomenon-driven) and the longer-term creation of value for stakeholders (strategy-driven). It will do this through the effective anticipation and deployment of talent to future needs. Talent strategy ensures the right mix of skilled health workers in the right place at the right time with the right resources needed to perform their jobs today and in the future and 'management support to enable them to work effectively to their full scope of practice' (Squires et al. 2015: 1).

In order to take this beyond purely developing processes, a strategic narrative for talent is important to engage key stakeholders in the organisation to the benefits of talent management over the longer term.

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The narrative emanates from a dialogue between the board, executives and senior managers, together with talent, human resources (HR) or organisational development (OD) professionals, and will arise from the unique context of the organisation. The narrative will articulate the necessity of achieving identified 'outside in' deliverables and frame talent strategy accordingly. It will anticipate and justify the expectations that will arise from focusing effort and resources on talent and talent management; it will provide clear definitions of both terms and a perceived existing position; it will articulate the necessity for, actions to deliver, and benefits of talent management. The strategic narrative will explain how an organisation intends to deal with both BAU (business as usual) and the potentially disruptive forces (DuBois and DuBois 2012) surging through the health sector by ensuring that talent management is focused on high performance, which is increasingly a requirement at both the national and organisational level (in hospitals, for example (Taylor et al. 2015)). Finally, it will form the basis from which a talent strategy for health can be developed and has links to longer-term objectives or transformation and will facilitate the organisation's actions to deal with both. In all cases, talent strategy is a response to organisational dynamics which in turn are a response to external forces (demographic, social and economic) or stakeholder requirements (political and economic).

For some, talent strategy is focused on the management and development of those in high-level leadership roles. For others, talent strategy is a whole workforce approach with activities and processes that, on the one hand, concern the identification of critical or key positions (those which differentially contribute to the organisation's sustainable competitive advantage (Collings and Mellahi 2013: 304)) and the development of a talent pool of high-potential and high-performing incumbents to fill these as well as, on the other hand, systems and processes to ensure that talent management covers a broad swathe of the workforce to ensure the maximisation of contribution. Effective talent management will be an output of a strategic process which in turn will enhance the value of the organisation or its competitive position whilst improving employee commitment (Sonnenberg et al. 2014), competence and contribution.

Thus, a definition, taking account of the unique requirements of the health sector, may be put forward as:

> Talent strategy in the health sector is that activity which determines the scope of talent and talent management, sets the long-term direction, and ensures resource allocation to and development of people identified as providing professional expertise or operational competence for the achievement of the organisation's goals.

The strategy can be developed on the basis of organic growth from existing activity. But it may also require a paradigm shift in HR for health, future investment 'to finance a modernized system for the production of a diversified workforce' (Zhao et al. 2013: 799) and, since healthcare delivery is highly labour-intensive, will involve both talent management at the individual level and the creation of diverse and talented teams with the right level of skills and competencies to meet population health needs (McPake et al. 2013: 841; Maeda et al. 2014: 42; Tomblin-Murphy and Rose 2016).

Talent Strategy Is at the Heart of Human Resources Management

In either case, talent strategy is at the heart of HR management (Lawler 2005) and, aligned to a strategic workforce plan (the criticality of which has been identified by the American Hospital Association, the American Organization of Nurse Executives, and the American Society for Healthcare Human Resources Administration), is concerned with ensuring the right people in the right place at the right time with the right level of skills and behavioural attributes for enhanced organisational performance and goal achievement. In recent years, in spite of economic challenges caused by the recession from 2008, 'talent management has gained a greater strategic role within organizations' (Khilji et al. 2015: 236). The strategy can be from a resource-based view, which rather than referring to talent as people or employees, would adopt 'the distinct vantage point of

equating talent to "human capital" that is both highly valuable and unique' (Gallardo-Gallardo et al. 2015: 270), or a strengths-based view, which focuses on the fulfilment of the potential of all employees, making organisational opportunities and resources available towards increased performance.

The definition of talent strategy shows how it sets the direction in which talent and talent management should travel to achieve organisational goals and the allocation of resources to effectively deliver the attraction, retention, reward, development and deployment of people in specific leadership and management positions on the one hand and the development of a culture of opportunity for all employees on the other. In a general sense, strategy will be successful if it addresses critical or value-adding objectives and if it is not mistaken for a goal ('many bad strategies are just statements of desire rather than plans for overcoming obstacles' (Rumelt 2011: 32)) and has a clear definition of the challenge it is facing. Successful talent strategies will work when they are focused on supporting or driving business or organisational strategies, are comprehensive, add value to the organisation, and enable the organisation to build its distinctive competencies. Talent strategy takes account of the specific contingencies or contexts of the organisation in designing, constructing and implementing a long-term approach (Joyce and Slocum 2012: 184; Ready and Conger 2007, Ready et al. 2014: 64; Schuler 2015).

The influences on the context are diverse and include social, demographic and political forces outlined in earlier chapters on the one hand and supranational or national organisational policy and guidelines on the other. In addition, there will be complex internal dynamics, including a multi-generational workforce with a range of expectations in terms of their work, life and career. Crafting a way through these forces and recommending how organisations face the challenges constitute the essence of talent strategy. To do so will require external and internal labour market insights as well as the policies of external agencies. Talent strategy setting will use these data and projections of future workforce requirements to facilitate decisions with respect to how the totality of resources, processes and programmes within the talent management definition are directed to the achievement of the organisation's people strategy, which in turn are directed towards the organisation's overall strategy.

Crafting a Talent Strategy Will Involve Choices

In a health sector where resource is under pressure, talent strategy will involve choices about in whom, where and when talent investments are made. In some cases, talent strategy will support the objective to 'find and nurture the people that are needed to lead over the next 10 years' (Rose 2015) or in others it will support a broader objective of recruiting and retaining chief executives or 'a more diverse or inclusive leadership and benefits in terms of organisational performance, as organisations can achieve competitive advantage through people' (Powell et al. 2012). As in the definitions of talent and talent management, the strategy will also be a case of best fit rather than best practice. But once again, there will be common elements of approach that apply across the sector.

The onus on those involved in talent strategy setting is to articulate and reach consensus on the desired outcomes which will 'form the boundary conditions … and should be continuously checked and evaluated against these boundary conditions' (Bates 2014: 91). In this context, health system goals will inform the quantitative and qualitative levels of talented people necessary to achieve them and the talent management investments required for both. Such decisions will depend on establishing a starting position, a direction and the levels of investment to be allocated.

In the first of these, the talent management evolution matrix provided an indication of where an organisation was in terms of its existing position and was based on the two dimensions of conceptual acceptance and practical implementation. If this starting position is compared with that which is desired to achieve the organisation's goals and objectives, then it will be possible to identify areas of significant strength in talent, which the organisation will look to reinforce, or areas of weakness or gaps, which the organisation will look to rectify or fill. For example, an organisation located in cluster 2, that has a reasonably strong talent proposition with some acceptance by the senior management team and a reasonable investment, may decide that to attract, retain, manage and develop talent for future needs (due to, for example, organisational transformation, competition from other health providers or changes demanded by government), a more integrated approach may be needed. To achieve this will require, inter alia, alignment between talent management activity and business

goals, greater involvement on the part of line managers, investment in learning technology to embrace a broader swathe of the workforce into talent management activities, and leadership development as identified through succession management. The actions required to move from the 'as is' position to the desired state will be the talent strategy.

This sequence fits with that of wider organisational or business strategy setting in health. Porter and Teisberg (2006) have noted, for example, that 'a dedication to improving operational effectiveness is important for any organisation, but it is not sufficient. Every organisation needs a guiding strategy, which defines its goals and purpose, the business or businesses it will operate in, the services it will offer and the ways it will seek to distinguish itself from its peers' (Porter and Teisberg 2006: 151). To achieve these objectives, a process of strategy setting will be based on choice and so a range of options will be identified against which the organisation can decide on resource allocation to talent management. An analysis of options will highlight areas in which meaningful actions can be taken to enhance the talent position and this will form the basis of the talent strategy. It will enable a move in the direction that will support the organisation's longer-term talent and performance objectives. If effective, it has the potential to address the significant challenges faced by organisations (Sparrow and Makram 2015: 250) by showing how a talent management architecture can create value.

In this respect, Porter and Lee (2015) have argued that organisations need clarity about 'what they are trying to do, for whom in order to make the important choices about how to compete. Value for patients must be the overarching goal' (Porter and Lee 2015: 1682); furthermore, there is a requirement for an understanding of the nature and scope of the parts of the health sector in which the organisation is operating and, in a competitive market for health services, what is the nature of advantage for the organisation. Hence, 'organizations need a unique value proposition' (Porter and Lee 2015: 1682). Ingram and Glod's (2016) study found evidence of talent strategy being related to both competitive advantage (in private hospitals and clinics) or organisational effectiveness in public hospitals. Talent strategy and its relationship to organisational strategy span the public/private sector boundary.

The Antecedents of Talent Strategy in Health Sector Organisations

The antecedents of talent strategy will be supranational or national health sector goals and objectives, which in turn will inform health sector organisational objectives, which will be factored into people strategy followed by organisational talent strategy.

The World Health Organization (WHO), the European Union and the World Bank, amongst others, have published intelligence on the health sector labour markets which have drawn attention to the need for a macro-level, supranational approach to talent. The WHO's *Workforce 2030* report, for example (2016), or the European Union's *Action Plan for the Health Workforce* (2012) emphasised the need for a high-level understanding of health workforce dynamics. Research by organisations such as the National Institute of Healthcare Research or the King's Fund provide valuable insights into such dynamics at a national level, and at governmental level national talent development campaigns are initiated in response to a range of economic and demographic challenges, with the objective of dealing with the challenges of attraction and retention of skilled healthcare professionals (Wang 2011). At a profession-wide level, representative organisations such as the Association of American Medical Colleges make recommendations based on their own profession's perspective such as encouraging academic medical centres to integrate the development of leaders within an organisational cultural context that is set up to deal with changes in the US healthcare regime (Fox et al. 2011).

These studies provide essential information and intelligence that form the basis of strategy and it is at the organisational level where information becomes insight and talent strategy turns from being an abstract concept to a practical process.

By recognising the importance of attracting, retaining and developing talented people in the workforce over time, organisations will have actions and resources ensuring that either critical roles are filled in line with the organisational strategy (Gochman and Storfer 2014) or an environment in which talented people, wherever they are in the organisation, can achieve their potential and make a maximum contribution. In order to

respond to changing environmental conditions (Ready et al. 2014), talent strategy will involve a talent facilitation process (Kneeland and Wachter 2010) for learning, training and development needs or a wider brief to ensure organisational commitment (Nel and Rodriques 2015). The diverse nature of talent strategy and the influences of the context of the organisation on the strategic narrative means that variations in approach will be in evidence. In hospitals in Spain and Portugal, for example, 'organisational plasticity and flexibility' were key drivers of the approach to HR for health and the requirements on talent (Morais and Graça 2013), an approach mirrored in the rapidly evolving health sector in India, where a hybridisation of known HR and talent strategies was necessary because of the pace of change and diversity of organisations in the health sector (Srinivasan and Chandwani 2014).

Evidence of how health sector organisations develop their talent strategies shows the variability of both conceptual understanding and practical implementation of talent and talent management and therefore different approaches to strategic development. A study of the British National Health Service (NHS) found that whilst the process of talent strategy had been in place in the organisation for a number of years, there were still challenges with respect to the lack of a clear definition, conflicts in principles and purpose, too much focus on an exclusive approach, and further challenges with respect to infrastructure to deliver the strategy (Powell et al. 2013). Other research also showed that a health sector talent strategy could succeed only if it was a well-organised and well-structured system and took account of the unique circumstances of the organisation, its culture and practices, and the special needs of the country in which the organisation operated. Where these factors were in place, performance could improve (Frixou and Charalambous 2016). An Australian study recommended a broad framework for talent strategy which included training needs analysis to ensure that practitioners had the necessary skills to perform their roles effectively and a training and development response that minimised training times (Nancarrow 2015), whilst in the Middle East the ability to attract, hire, develop and retain leadership talent was a key goal and having leaders who had the agility to cope with significant change was critical (Martin 2015).

In these examples, talent strategy was crafted in the context of the organisation's unique strategy setting processes and culture.

Case Study: Talent Management and Strategic Workforce Planning in Healthcare—NHS Digital

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Introduction

NHS Digital is an executive, non-departmental public body and the national provider of information, data and IT systems for patients, service users, clinicians, commissioners, analysts, and researchers in health and social care. The organisation's role is to improve health and social care in England by putting technology, data and information to work. NHS Digital has been positioned at the forefront of the government's national agenda to radically reshape and digitise patient experiences within both the health and care system. This programme of work is underpinned by the development of new IT infrastructure, the innovation of software solutions as well as the development of a plethora of healthcare apps.

The scale, complexity and pace of change demanded present both enormous opportunities and challenges for the organisation, particularly in relation to the recruitment and retention of the right talent at the right time and in the right place. Even simply scoping, in both qualitative and quantitative terms, the capability and capacity required has proven difficult but not insurmountable through the introduction of a strategic workforce planning approach which is and should be directly linked to the talent management strategy within the organisation.

The Approach to Strategic Workforce Planning

NHS Digital formally organised its staff base into professional groups with the resulting impact that all staff are now employed within a profession aligned with their skills and experience and crucially the job role they have been employed to undertake. A new operating model was introduced at the same time as the profession approach which effectively separates staff in professional pools (supply) from demand (delivery priorities) and this approach necessitates a more mature and sophisticated approach to workforce planning than might previously have been evident within the organisation—this is an ongoing challenge.

As well as aiming to build vibrant professional communities across the organisation, professional groups aim to provide a clear view of relevant professional training requirements and to support staff in shaping career paths with professional competencies and consistent job descriptions. These objectives directly support NHS Digital's strategic workforce vision to:

> Empower our people and our organisation to be more flexible and agile in order to deliver the right things for our customers with greater efficiency and provide better value for money in line with the urgent needs of the health and care system.

The organisation of staff by professional expertise also directly facilitates workforce planning within the organisation, a point acknowledged by the external advisers who have recently reported on their assessment of NHS Digital's workforce planning approach. The adviser's final report acknowledged some strength in the commitment of the organisation to professions and the roles, responsibilities and networks created and facilitated by them. There were also, however, a number of recommendations set out which if implemented are designed to embed a workforce planning approach within the organisation which is more strategic as well as tactical. These recommendations centred on the introduction of workforce planning architecture and cultural alignment as well as the production of a first workforce capability plan for NHS Digital designed to respond to the talent capacity and capability challenges the organisation is currently presented with.

NHS Digital is coming to the point of finalising a first version of a workforce capability plan (end of March 2017) which aims to address the strategic workforce capacity and capability challenges facing the organisation. It includes a comprehensive assessment of supply as well as resource demand and therefore indicates a clear articulation of the gap in workforce talent terms set within a clear organisational context. The summary headline is that there is a significant delta currently between what the organisation needs to effectively resource delivery requirements all at once. The need to do so, however, is not an ongoing or permanent one in which case one of the key dilemmas in talent recruitment and retention terms is sourcing capacity and capability on a temporary time-limited basis. This is within an extremely tight labour market where many of the highly specialist skills required, including IT, digital and cyber security, are both scarce and highly sought after. An additional challenge is the increasing recognition that the professional pools may not always be at the cutting edge of their practice and so there is also a need to evolve and develop skills to meet business needs.

Within this context, the key and practical pieces of work emerging and contained within the workforce capability plan are as follows:

- Alternative sourcing (*to respond to the need to utilise temporary labour in certain circumstances*)
- Recruitment at scale (*to address some of the skills gaps identified*)
- Digital culture and leadership (*recognising the business that NHS Digital is in and the cultural and leadership challenge*)
- Segmentation and bespoking (*acknowledgement that to recruit, retain, engage and motivate talent there is a need to segment the workforce*)

- Prioritisation of critical professions (*a recognition that the organisation cannot tackle every talent gap within the same timeframe*)
- Alternative futures (*to respond to the challenge that not all professional pools contain the skills and expertise needed*)
- Retention and development (*there is a need to retain the key talent the organisation has*).

It is important to note that the agenda set out above is very much a strategic one in both workforce planning and talent management terms.

Linking Strategic Workforce Planning to Talent Management

So what does this all mean for talent management within NHS Digital? A comprehensive and well-received talent management strategy was produced by the organisational capability team in June 2016 and ratified by the executive management team thereafter. It was then necessary to relate this to the context of the organisation to really begin to impact on the recruitment, retention and engagement of capacity and capability both within and in terms of attracting talent.

The planning process directly focused on longer-term workforce challenges facing the organisation, including the ability to attract highly specialised roles into the organisation. One example of such a piece of work is that NHS Digital has adopted a 'grow our own' approach over the last couple of years in an attempt to ensure the pipeline of scarce talent through the organisation using mechanisms such as graduate schemes, apprenticeships, work placements and internships. This approach is starting to yield results with, for example, 9 of 10 graduates appointed across several difficult-to-fill skills areas, including within IT in January 2015 securing permanent roles with the organisation in early 2017.

With the formulation of a strategic workforce plan, however, the organisation is now at the point of being able to revise the talent strategy to ensure that it is meeting the business needs in terms of the delivery of the right staff at the right time and in the right place. A number of initiatives in response to business problems in workforce terms narrated in the workforce capability plan are starting to come to fruition. For example, it is clear that permanent recruitment and a resulting increase in organisational headcount will not address the short-term skills gaps and numbers identified. Therefore, a piece of work on alternative sourcing has been instigated to understand firstly what types of skills and numbers within critical professions could be sourced and secondly how the organisation within the confines of public sector constraints could actually go about securing the talent required.

A further example of the direct impingement of the strategic working planning approach adopted in the organisation's talent strategy is the recognition that as an organisation with part of its workforce vision to ensure that all staff are customer-focused, we will need to train and develop staff in customer service skills and some thought is currently being given to how and what it would take to make this happen. Furthermore, NHS Digital is starting to really

focus talent interventions on its areas of critical capability as identified within the workforce capability plan which is in effect a form of segmenting the workforce. There is also recognition that further segmentation by age, gender, location and so on will provide additional clarity on NHS Digital's offering to various parts of our existing and future workforce to secure the skills needed, motivate our workforce whilst in employment, and retain skills.

In summary, it is clear that this integration is key. The workforce capability plan in effect identifies the organisation's future workforce needs in both capacity and capability terms and this is being used as the basis for talent strategy and management within NHS Digital.

Developing a Strategic Framework for Talent in Health

Since most units in the health sector are knowledge-based organisations, 'the education and skills of its staff members can impact management practices and patient outcomes' (Agarwal et al. 2016: 344). Developing a talent strategy can make a positive contribution to these outcomes. There is a common desire to ensure the alignment between talent strategy, the organisation's people strategy and the overall business or organisational strategy. Integrating fully with the organisation strategy is a long-term aspiration echoing the conclusion that:

> The sum total of all of the potential of individual talent in an organisation will be that organisation's theoretical competitive position. If these potential outputs are sufficiently different and ahead of the outputs of competitor organisations, that will be the organisation's competitive advantage. If these potential outputs are converted to real outputs, then that will be the organisation's competitive success over time (Turner and Kalman 2014: 51).

The identification of 'outside in' deliverables and of those inside the organisation accountable for their delivery and the allocation of resource to talent management are the essential features of talent strategy. It is possible to identify four key groups of activity associated with this, as outlined in Fig. 6.1.

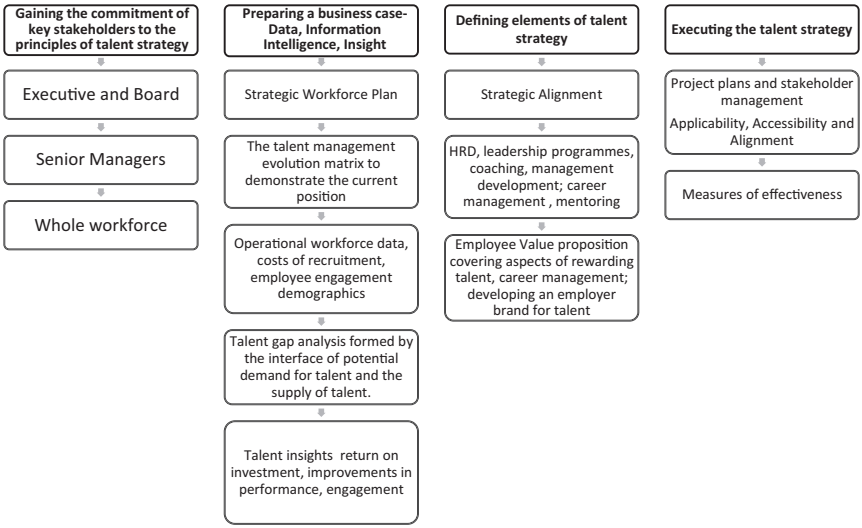

Fig. 6.1 Key groups of activity in crafting a talent strategy in the health sector

Gaining the Commitment of Key Stakeholders

The first is the need to gain the commitment of the key stakeholders to the principles of talent strategy. This will ensure that talent management is developed beyond stage 1 to a more aligned or integrated process resembling stages 3 or 4.

In those organisations where talent management is a new or emerging concept, the board of directors and executive team will be the first group who will need to see the benefits of investment of time and resource into talent. The process of 'outside in' deliverables as a means of informing the objectives of talent strategy will be an important contributor and therefore the integration of HR and talent activities into organisational strategy is critical (Trebble et al. 2014). In those organisations where talent management is already in place, this will be an effort to move the senior managers of the organisation up the conceptual acceptance axis outlined in the talent management evolution matrix. Ready et al. (2014) have noted that 'commitment from the top executive team is central to building and maintaining this business-first mind-set. Game-changing leaders not only excel at articulating the vital importance of talent management

but also are heavily engaged in their companies' actual practices. They demand that their line leaders be accountable for spotting, developing, and retaining the next generation of leaders' (Ready et al. 2014: 64).

In a study of successful health partnership organisations, it was found that the involvement of the executive was essential to the delivery of effective HR management of which talent and talent management were a part. The make-up of this executive team varies among health organisations, but research into performance management in Belgian hospitals reinforced the point that there was benefit to having a mix of physicians as well as administrators in the top team when it came to implementing performance management (de Harlez and Malagueño 2016). In some health sector organisations, senior talent champions are appointed to take board-level responsibility for the development and monitoring of the strategy. A combination of different insights amongst the senior stakeholders will enhance the efficacy of decisions made about direction and resource allocation.

Public sector studies in Thailand, Malaysia and Singapore (Poocharoen and Lee 2013) have shown the necessity of clarity about the definition of what is included in the sphere of 'talent' and a flexibility of approach towards other HR systems. It is likely therefore that gaining commitment in complex health environments with multiple agencies will require a deft touch. This can be in the application of policy (Oborn et al. 2011) or, as in the USA, the commitment of health sector leaders able to respond to complexity and volatility experienced during transformation processes, as the talent strategy may well involve (Guerrero et al. 2016).

In all cases, the commitment of the senior management team will be vital for the successful development and delivery of talent strategy in health sector organisations.

Preparing a Business Case for Talent Strategy

The use of analytics to demonstrate the business impact of HR and talent management activity is a growing trend (Douthitt and Mondore 2014). But this can be problematic in health where issues in terms of reward and

goal congruence, the organisational dynamics between clinical and operational processes and competing priorities from a diversity of stakeholders 'create unparalleled complexities for the effective use of management control systems' (de Harlez and Malagueño 2016: 2). Hence, the predominant 'case' for justifying the investment in talent management in health to date has been largely qualitative and related to knowledge and skills improvement, lower turnover and better retention (Ingram and Glod 2016). The factors that will change this approach are cost pressures whilst still being required to provide quality healthcare to more people. There is the potential to have a structured, return-on-investment approach to all investment, and talent management will be no exception. Hence, the crossover of methodologies from other sectors such as the balanced scorecard (Shukri and Ramli 2015) as a suitable framework to provide information on health sector organisational performance with respect to talent.

Hence, the second group of activities in preparing a talent strategy will be the preparation of a business case. The admission of HR management in general and talent management in particular into the mainstream of organisation operations means that the functions will in many cases be subjected to the same rigour in gaining investment as other functions. The preparation of a business case for talent will be an important component of developing a talent strategy. Increasingly, the presentation of evidence-based and data-driven approaches to talent, enhanced by the advent of HR analytics, will be expected. Information from the strategic workforce plan, operational data such as labour turnover, and information on retention and succession will be combined with external labour market data to form the base case. More sophisticated analysis from human capital analytics such as return-on-investment calculations, predictive modelling and performance profiling can be developed from these data and investment extrapolations to provide intelligence. In some cases, this part of the talent strategy setting process leads to the identification of a talent gap (that is, that difference between forecast demand for talent and the level of supply anticipated after labour market data and internal availability of talent data have been reconciled). In response, strategically designing the future (Mensik and Kennedy 2016) will be evidence-based.

The talent gap analysis can be the basis of the talent review, a board-level activity, or it can be an output used to operationalise the talent strategy at its later stages. At the board level, there will be questions about succession to senior positions and the challenges associated with them, the availability of a pool of talent to fill managerial positions in the longer term or questions about the demographic make-up of the workforce and whether this reflects inclusion and diversity objectives. The wider talent gap analysis will inform career management and whole workforce development on the assumption that 'focusing on the frontline hospital staff (i.e., nursing staff), rather than strict hierarchal structures of authority within the hospital organization in the provision of care, has positive impacts on organizational performance' (Hockenberry and Becker 2016: 890). However, the key to successful strategy will be the ability of those responsible for its development to offer insight about the advantages of investment in talent, especially important as 'organizations have acknowledged the need to embrace talent management practices to forecast and manage human capital more effectively by appropriately aligning business objectives and strategic goal setting to prepare for the growth and expansions that occurs within organizations' (Martin 2015: 112). These can be about the strategic direction of the organisation and the talent implications of this or operational insights about succession or leadership development.

Identifying the Key Elements of Talent Strategy

The third group of activities will be concerned with designing the key elements of talent strategy. Traditionally, these have been in the areas of leadership development for succession planning, the creation and development of talent pools, and the recruitment and management of high potentials to provide a supply of leaders and managers over the medium to long term. However, the broadening of the talent management approach to embrace the whole workforce means that attention is given increasingly to other activities. In the UK, for example, an inclusive approach was advocated 'to rediscover neglected talent and focus on developing the people skills of their existing managers' in addition to

those of high potential individuals' (McPherson 2015). Career management and opportunity, mentoring availability to a broad range of employees, the inclusion of talent as part of a wider employee value proposition and the development of an employer brand to all contribute to the attraction and retention of talented employees. Research into the experiences of nursing employees in China (Zhou et al. 2016) found that a critical factor in the intention to leave (emigrate) or stay was the availability of career opportunities as part of a wider value proposition, reinforcing the point about the need for a holistic approach to what is included in talent management tools.

However, the starting point for all of these, and the ongoing benchmark for their relevance will be the alignment to the organisational goals, its strategies to achieve them and the overall people strategy. Indeed, the need to ensure that talent strategy is closely aligned with the corporate strategy has been identified by the UK Chartered Institute of Personnel and Development as an absolute priority. In health sector organisations, the priorities to be addressed by the tools of talent will be determined by the unique context of each organisation. For example, this might be issue-based such as leadership development for women in US hospitals; a study showed that women executives constituted only 24% of senior executives and 18% of chief executive officers in the USA (Hauser 2014). Or it might be on a broader platform such as in New Zealand where the development of nurse practitioners was a priority and organisations would have this objective as one of the key drivers of their talent strategies (Carryer and Yarwood 2015). A comprehensive study of managerial development in the British NHS reinforces the point (Powell 2014).

The organisational brief for the development of a talent strategy is inevitably tied in with national strategies for health, and therefore the tools of talent strategy will reflect a mix of national and organisational objectives. In the predominantly private health sector of Abu Dhabi, for example, the overarching objective of providing access to affordable healthcare to all those who lived in the Emirate required not only the expansion of existing health service facilities but also building new ones (Vetter and Boecker 2012). This would be by a mix of governmental and private investment in the sector. However, national health objectives

would also require the upgrading of health professional education systems, continual professional education for clinical staff, and a range of scholarship programmes for new entrants to the health profession. These would require a broad-based talent strategy at both the national and the organisational level.

The tools of talent management in support of delivering the talent strategy therefore contain elements relating to leadership and management development, whole workforce development, and the broader consideration of combining these in the form of an employee value proposition. Figure 6.2 shows how these relate to each other.

The identification of the organisation's objectives and the HR strategies that support them will be the precursors to the development of a talent strategy. Having done so, the strategy will include the following:

- In those organisations where an exclusive or selective focus has been identified as the priority for talent strategy, the main tools of talent management will be leadership and management development programmes. These can be either external and formal or internal and formal and in the contemporary organisation might include executive coaching for the most senior leadership roles or

Fig. 6.2 The tools of talent management in support of delivering talent strategy

performance coaching for managerial roles. A further more informal developmental action is increasingly secondment or allocation to a strategic project.

- Where an organisation has a more inclusive or pluralistic focus embracing a greater proportion of the workforce than that above, a whole workforce response will mean the creation of a wide range of career and development opportunities that are designed to fit the specific and unique culture of the organisation. In the USA, for example, the changes brought about by the Affordable Care Act and the Health Insurance Portability and Accountability Act incentivise or penalise US health facilities on the basis of specific quality measures with an emphasis on training in industry-wide standards. This has prompted small, community-based healthcare organisations on the one hand to large acute care hospitals on the other to invest in the recruitment, training and development of talent and a talent strategy that is likely to be broad-based (Ho 2016).
- In both cases, an appropriate employee value proposition will require that talent strategy be more than a development strategy. It will therefore include elements of attraction and recruitment, reward and engagement.

The best fit rather than best practice approach is appropriate for health sector organisations as they decide on the tools of talent strategy.

A Plan for the Execution of Talent Strategy

The final group of activities with respect to the preparation of a talent strategy will be concerned with execution—the practical implementation axis on the talent management evolution matrix—which will be as critical as any other facet and the skills to do so shouldn't be underestimated. A study of the application of talent management in the UK, for example, noted that whilst a broad range of initiatives were included in a variety of talent and leadership guidance plans advocating a long-term view, progress was mixed with the conclusion that it was difficult to determine whether there were positive results. The prime challenge

was that 'principles do not appear to have been translated into practice, and some appear to be in conflict. In particular, 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' (Powell et al. 2013: 306). Overall implementation performance of talent strategy found that there were vulnerabilities to talent management, particularly in talent acquisition, retention, and replacement activity within global healthcare value chains (Montgomery and Oladapo 2014). The relevance of developing a talent strategy that has three characteristics of applicability, accessibility and alignment is particularly apposite.

Measuring the effectiveness of talent strategy in the health sector is a requirement that is increasing in intensity as part of the need to achieve cost and performance requirements or targets. At the strategic level, healthcare organisations have applied the balanced scorecard approach with the conclusion that it had the potential to make a contribution to strategy implementation through the 'strategically-oriented performance measurement systems embedded within it' but came with the proviso that its effective application should be adapted to the unique circumstances of healthcare organisations (Bisbe and Barrubes 2012).

Nevertheless, as the importance of talent strategy increases in the health sector context, so will the demand for more robust metrics so that organisations can assess performance in a tactical sense and the return on the investment in talent in a more strategic one. Table 6.1 shows some of the measures associated with talent strategy.

The traditional approach to talent metrics has been to focus on tangible benefits. And these have mostly been about the analysis of current performance metrics against historical ones. The most basic is labour turnover and by how much talent interventions have reduced this. Likewise, retention rates, a particular priority in the health sector, could be subjected to 'before' and 'after' analysis. Other measures commonly deployed as outcomes of talent-based interventions are diversity, movement of those within talent pools, and various metrics about numbers or percentages of people on management courses or programmes. A recent study of company annual reports found that measures of effectiveness of

Table 6.1 Measures of effectiveness of talent strategy identified from health sector organisational studies

Tangible benefits	Intangible benefits
Increase success in achieving patient outcomes	Clinical professional satisfaction
Improvements in clinical outcomes	Improved health sector unit reputation
Improvements in financial outcomes	Improved reputation of the profession
Improvements in productivity	Improved external stakeholder relations
Improvement in leadership capacity	Better succession management to senior positions
Number of appointable people for senior positions	The creation of intellectual property in health services or processes
Availability of talent to deliver operational services	
Availability of talent to deliver strategic projects	
Better Information about organisational talent to fill critical roles	
Improvement in leadership capability	
Lower turnover	
Improvement of retention rates	
Increased employee engagement	
Inclusivity and diversity measures	
Knowledge and skills improvement	
Improvements in talent and people management processes	

Sources: Bisbe and Barrubes (2012), Powell et al. (2013), Satiani et al. (2013), Ingram and Glod (2016).

learning, training and development included total days or hours of training; average hours of training per employee per annum; training expenditure as percentage of employee costs; numbers of employees on or completed programmes; number of people on structured training programmes; amount spent on training; amount spent on training per employee; number of programmes or courses attended; changes in inclusion and diversity metrics as a result of interventions.

However, there is recognition of the importance of intangibles and the effect that talent strategy could have on these in the health sector. Intangibles in this case mean those aspects of the organisation that aren't readily identifiable in annual financial reports, including corporate reputation, an employer brand that not only reflects the values of the organisation but embodies a reputation for being a good place to work and have a career. In health, there is a recognition of the importance of corporate reputation as a marketing tool in territories from Thailand to

Spain and in German hospitals (Srivoravilai et al. 2011; Mira et al. 2015; Schermuly et al. 2015). Intangibles are less easy to measure in any structured way but are important nonetheless and can be reflected in such things as employee attitude surveys.

The measurement of the effectiveness of talent strategy is in itself tied up with bigger forces of HR analytics, which themselves are open to different interpretations. What is known is that for many organisations HR analytics are changing the nature of people management and development because they give HR valuable workforce intelligence about past and present trends but also, through predictive analytics, future ones. What is less well known are the pace and scale of this change.

Examples exist about HR analytics providing greater insight about the value of individuals, teams and groups in organisations. It has been argued that 'companies that build capabilities in people analytics outperform their peers in quality of hire, retention, and leadership capabilities, and are generally higher ranked in their employment brand' (Deloitte 2015). At the other extreme, there is a point of view that HR analytics remained a significant challenge for many organisations. There can be variability in both interpretation and practice of HR analytics, meaning that potential benefits were not being realised (CIPD 2017). So whilst the transformational potential of HR analytics was accepted, the realisation of that potential in practice was still evolving depending on the maturity of organisations in their HR strategy and practices.

Conclusions and Implications for Practice

Talent strategy is a process of allocating resources effectively and ensuring that those resources are used to align talent management activity to the achievement of the organisation's goals and objectives. If the strategy is effective, it will overcome some of the challenges faced by organisations (Sparrow and Makram 2015: 250) by addressing how a talent management architecture can create value for the organisation.

The starting point for the strategy is the talent management evolution matrix, which provided an indication of where an organisation was in terms of its existing position. This provided the foundation or platform on which subsequent strategy could be crafted. Prioritising the key areas to be addressed by talent strategy and allocating resources to those areas will enable the organisation to move in the direction that will support the longer-term talent and performance objectives.

If this is done effectively, it can improve patient outcomes and increase productivity and can ultimately be used to identify a return on investment for talent that justifies the approach (as judged by competing investments in other parts of the organisation). In some organisations, this will focus on 'two critical functions—recruitment and retention—involving employee management and more specifically, the managing of high performers' (Craig 2015: 208). In this case, a strategy that concentrates on attraction and recruitment through the development of an appealing employer brand and the availability of competitive rewards and development will be the tools of talent. On the other hand, a more holistic, pluralistic talent strategy will involve developing tools and applications for the majority of the workforce, will include active involvement of executives and managers in its implementation at all levels or nodes of the organisation, and will have whole workforce metrics to support the investment in talent.

There are examples of health sector organisations operating at both of these extremes of the talent spectrum. In all cases, some conclusions can be drawn:

- In the first instance, the chances of delivering an effective talent strategy will be enhanced by having clarity within the organisation of what is meant by talent and talent management and the segments of the workforce addressed by them. There is no better or worse definition. Instead, the organisation will look for best fit to its specific and unique circumstances. A shortage of a particular clinical group will determine the priority; a transformation programme affecting the whole workforce will necessitate a different emphasis.
- Secondly, health sector organisations developing a strategic approach to talent will have a greater chance of success if they have managed the

stakeholders accordingly and the chief executive officer is actively involved in identification of talent (at either a leadership or a senior managerial level). In addition the creation of the tools of talent for a whole workforce approach and the engagement of the workforce in their deployment are critical.

- Thirdly, that there is as much thought given to the execution of the talent strategy as to its creation. This will involve the creation of implementation plans, clarity of roles and responsibilities for their delivery, the basis of measures of effectiveness built in at the initiation of the talent strategy, and a road map for implementation.

Finally, it is important that the component parts of talent strategy be connected in a meaningful way and that they themselves be integrated with the organisation's overall people strategy. This means ensuring a line of sight between the desired outcomes of the talent strategy and the organisation's overall objectives.

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7

Succession Planning and Leadership Development

The Importance of Leadership and Management

Leadership is an essential health sector practice which has a direct impact on clinical and organisational outcomes and an indirect effect on all other elements of the operational environment (Longenecker and Longenecker 2014; Redknap et al. 2015: 266; Sarto and Veronesi 2016), and leaders are critical to the success of healthcare systems in implementing and sustaining strategic change (Block and Manning 2007). Hence, developing high-performing leaders at multiple levels in the sector is important if the vision for transforming healthcare is to be realised (Mazzoccoli and Wolf 2016). It follows that understanding the characteristics inherent in such leaders is a priority for any leadership development activity. Amongst the identified leadership styles in this context are to be values-driven (Dye 2017) and to adopt authentic leadership which can foster relational social capital and positive health outcomes (Read and Laschinger 2015). However, these are just two of a 'vast number of frameworks and theories' (Edger 2012: 115) that have fed into the leadership debate.

Leaders have been defined as those who could 'mobilise others to want to get extraordinary things done in organisations … transform values

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into actions, visions into realities, obstacles into innovations, separateness into solidarity, risks into rewards … create a climate in which people turn challenging opportunities into remarkable successes' (Kouzes and Posner 2007: 8), or they were those who could influence a group of people to commit willingly to a common goal (Edger 2012), or they fit the profile of Collins's *Good to Great* 'Level 5' (2001), balancing personal humility and professional will to make the right decisions happen. A significant study synthesised the traits of effective leaders as charisma, clarity of vision and strategic objectives, decisiveness, inspirational communication, integrity, trust and delegation, honesty and consistency with a genuine interest in staff (Alimo-Metcalfe and Alban-Metcalfe 2003). Other analyses of the attributes of leaders included those associated with behavioural and style theories, contingency and situational leadership, whether leaders were transformational or transactional in their approach, and the importance of emotional leadership. In most of these analyses, leaders are those people at the apex of the organisation who are responsible for setting strategy and policy. These definitions often focused on the inherent competences or characteristics of individuals and had a focus on individual traits. Unsurprisingly, given their importance, creating a sufficient number of leaders to operate at the highest level, leaders who could either provide continuity in the organisation's strategy or transform it to a new ideal, leaders who could make the right decisions and who were able to persuade others to deliver the operational outcomes of the decisions has been the focus of talent management to date.

But traditional approaches to leadership have come under some scrutiny with the conclusion that 'although it is one of the most-observed concepts, no universally accepted definition or theory of leadership actually exists' (Scully 2015: 439). Subsequent analyses identified the need to extend the definition of leadership beyond the 'role of charismatic individuals … in setting compelling visions to which all organizational actors are expected to subscribe' (Collinson and Tourish 2015). It was noted that the traditional definition paid little attention to power dynamics, the importance of organisational and environmental context, and the significance of follower engagement. Nor did it take sufficient account of the fact that leadership took place at levels other than at the most senior. Goffee and Jones's (2006) point of view that leadership was situational

and non-hierarchical has significance and is one which resonates most in a world no longer characterised by bureaucratic lines of demarcation with complex and fluid organisational networks and matrices supplementing classic hierarchies. Furthermore, there is recognition of the difference between the concept of *leader*, a person who has appropriate individual traits and emotional intelligence, and *leadership*, which concerns the social exchanges that take place in organisations at multiple levels.

This dynamic picture of leaders and leadership has implications when considering talent management and, in particular, leadership development. It also has an impact on which people and roles should be considered in the succession planning process. In both instances, a contemporary view is that leaders exist at and leadership takes place at multiple levels. Understanding the implications of this for both succession planning and leadership development is critical to the success of talent management.

Leadership at the Highest Levels of Healthcare Organisations

The constant and rapid change that is a feature of healthcare highlights the need for strong leaders and leadership at the highest levels of health sector organisations (McAlearney 2010). The abilities of health leaders have been identified as being critical to the achievement of the organisation's objectives, whether these relate to clinical outcomes (Ang et al. 2016) or business and operational performance. Effective leadership is essential to an effective healthcare strategy (Wells and Hejna 2009).

In this context, leaders in health have been defined as 'people who can guide others to achieve a desired goal and demonstrate the ability to augment productivity, create sustainable change, and inspire others to engage in professional development' (Chan et al. 2015: 342). It was noted that to be successful 'a leader must have a clear understanding of where the organization is today, the current health care climate, and the mission and vision of the organization. Understanding the gaps that exist in care and developing creative ways to fill those gaps with the team is imperative to empower staff and engage them in solutions' (Elwell 2015: 313). Health sector leaders are those who 'establish direction, align people,

motivate and inspire colleagues towards a common goal' (Scully 2015: 439), often in an environment of unprecedented complexity (Daly et al. 2015). It has been argued that, amongst these multiple definitions, 'servant leadership aligns well with the needs for leadership in health care because health care providers' work, and their life calling, is to serve their patients. The ethical and moral aspects of servant leadership require a healthcare provider to put the physical, emotional, and financial needs of the patient first. The skill set of listening, empathy, awareness, healing, and persuasion all contribute to a healthy healthcare provider-patient relationship' (Trastek et al. 2014: 380).

It is important to have clarity because leaders are critical to achieving the care, compassion, courage, commitment, communication and competency enshrined in healthcare organisations (Leigh et al. 2015) in three ways. Firstly, they articulate the vision of the future to which the organisation aspires and which enables business decisions, plans and activities to be directed accordingly (Gulati et al. 2016). Secondly, they create a culture in which talented individuals can deliver these objectives and at the same time achieve their full potential. Thirdly, leadership at multiple levels is an important factor in delivering high-impact healthcare programmes. It is out of the recognition of these points that strenuous efforts are being made to spread leadership training and development on a global basis to ensure that health sector organisations will be best equipped wherever they are based.

For many, leaders exist at and leadership takes place at the highest levels of the organisation and this has produced a positive impact on motivation during times of transformation and change (Deschamps et al. 2016). The implication is that the presence of skilled and knowledgeable leaders will facilitate the organisation's ability to deal with such change. To do so, health leaders manage 'the gap between the former traditional model of healthcare and a future emerging model that remains shrouded in the mist' by examining 'the scope and nature of the change we are facing during this period of turmoil and ambiguity, in order to develop effective strategies for leading organizations and the profession into the future' (Fitzsimmons and Rose 2015: 34); and on the other hand, leaders can facilitate shared governance and a united voice as means to successful transformation of healthcare organisations (Nelson and Pilon 2015).

The complexity of leadership in health with demands for public advocacy, networking and negotiation (Kumar et al. 2015) as well as those skills 'normally' associated with the role places a particular emphasis on the type of leader and leadership required. A European study demonstrated the scale of the challenge by identifying fifty-two competences in eight domains for health leaders, including the ability to understand health issues and synthesise divergent viewpoints and an understanding of reflective leadership, servant leadership, adaptive leadership and the application of emotional leadership (Czabanowska et al. 2014). Furthermore, in India, leaders in healthcare were expected to have competence in multiple domains, including technical, cognitive, and emotional competences, because 'to be a successful leader one needs to regularly review one's emotional competences and improve these by learning from interactions one could have done better' (Kumar et al. 2015: 161). In the complex and changing landscape of US health, 'effective leaders at the frontline' (Kim et al. 2014: 545) needed the ability to negotiate through the complexity and provide strategic direction. A growing number of clinical specialists moving to senior healthcare leadership positions adds a further dimension (Henson 2016).

In the UK public health sector, 'five talents for public health leadership' were identified—mentoring-nurturing, shaping-organising, networking-connecting, knowing-interpreting and advocating-impacting (Day et al. 2014)—whilst in Africa the ability to influence, communicate effectively and build relationships (Shariff 2015) was important because influencing health policy was a prime objective of health leaders.

A synthesis of the analysis that has taken place for leadership in the health sector highlights three critical areas of competence. The first is the personal insight that should be demonstrated by leaders at whichever level they operate. This will include popular concepts such as emotional intelligence. The second is that of professional credibility which will need to be demonstrated in whichever leadership role is undertaken (clinical, technical or managerial) if followership is to be secured. The third is that of an understanding of the organisation's dynamics if the leader is to negotiate his or her way through systems and processes in order to secure resources to deliver unit or departmental objectives. Figure 7.1 shows some of the characteristics within these three areas.

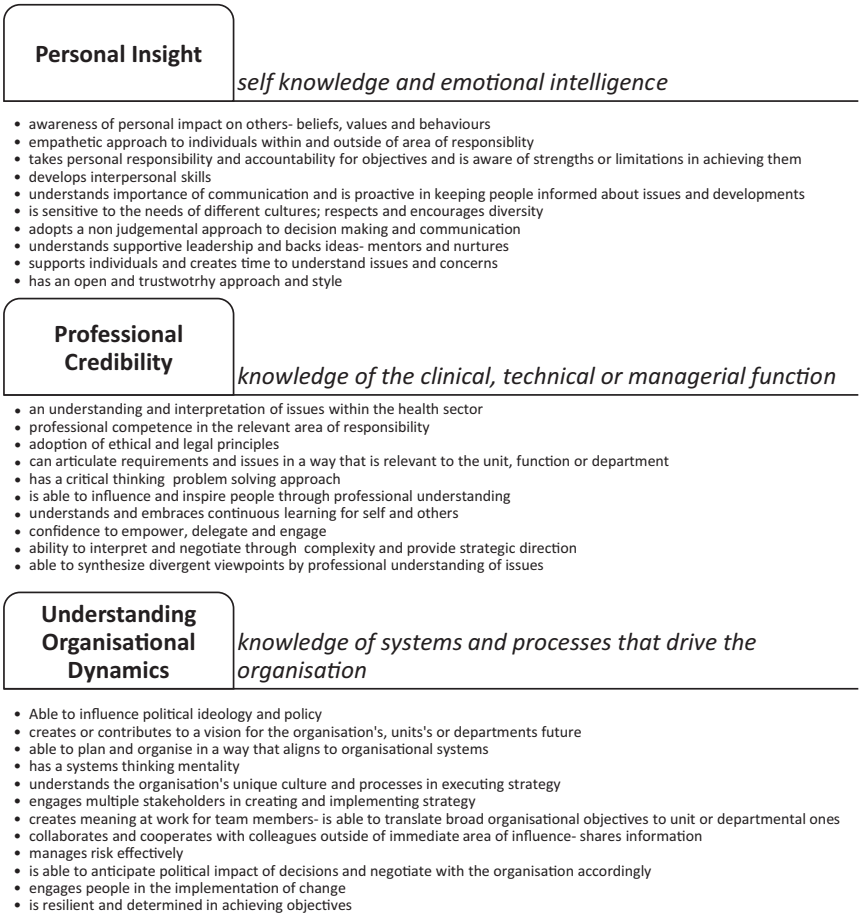

Fig. 7.1 The competences associated with leaders and leadership in the health sector. Sources: Czabanowska et al. (2014), Day et al. (2014), de Jong et al. (2014), Goleman (1996, 1998), Kim et al. (2014), Scully (2015), Kumar et al. (2015), Love and Ayadi (2015), Shariff (2015), Hamlin et al. (2002, 2010)

These studies reflect the fact that at the highest level of the organisation leadership in health is a complex process. Having the right leaders in place, backed up by effective leadership development to support individuals through this complexity, is critical. Successfully doing so can have a positive impact on the achievement of the organisation's mission, goals,

strategy, stewardship and policy. This is why leadership has been the main focus for talent management in many health organisations.

Devolved Leadership in the Health Sector

The performance of leaders and their influence on health strategy were instrumental in increasing the number of active health professionals and the opening of new institutions for higher education in healthcare and training schools for paramedical staff and midwives (Kingue et al. 2013). Furthermore, investing in transformational leadership development reduced turnover among public sector mental health providers (Green et al. 2013). Where organisations in the South African healthcare sector (Stander et al. 2015) encouraged authentic leadership, it led to higher levels of optimism, trust in the organisation and eventually work engagement. It can also moderate follower intentions (Green et al. 2013). These examples show the power and importance of high-level leadership. But there is also evidence for a broader scope in the definition of leadership in health which is important to deal with organisational complexity.

The situational and non-hierarchical nature of the contemporary leadership view implies that the concept is extended beyond a few at the very top of the organisation and their successors. In such cases, the question of overlaps with what has traditionally been considered management is raised, for example, by describing nurse leaders as leaders and at the same time 'the most senior people in the hospital—the executive and board—are regularly described as the leadership team … consequently, there seems to be little in the way of an easy explanation as to what leadership and management are' (Ellis and Abbott 2015).

There have been attempts to differentiate between the two over time. Bennis (2001), for example, tried to distinguish the leader role from that of the manager, believing that managers administered whilst leaders innovated, that managers maintained the running of the organisation whilst leaders developed new ideas, strategies and concepts, and that managers were concerned mainly with systems and processes whilst leaders with people. This had credibility where roles were clearly delineated and the boundaries between what was leadership and what was management could be identified. But more recent analyses concluded that leaders

could not simply delegate management; and Mintzberg (2011) argued that instead of being distinguished from leaders as performing separate roles, managers should be seen as leaders and that leadership should be seen as management practiced well; 'the operation of leadership forms one of the elements of management practice. Different situations require the application of different skill sets, but those skill sets can reside in the same person' (Ellis and Abbott 2015: 97).

The enhanced view of leaders and leadership has been caused, in part, because health sector organisations are inundated with change caused by 'multifaceted developments in the technological, political, financial, professional, scientific, and social realms are rapidly redefining the nature of healthcare and healthcare delivery' (Fitzsimmons and Rose 2015: 33). In this context, leadership will be essential at multiple levels if organisations are to perform effectively.

In the British NHS, for example, the emphasis has moved over time from a main focus on a cadre of senior leaders who could manage large-scale transformation (still a critical area), to leaders and managers at multiple levels embracing smaller clinical units and multi-disciplinary teams, to those leaders who are skilled at working across systems and boundaries (Department of Health 2009). This is leadership along a spectrum. It is distributed leadership as noted by the UK National Leadership Council, which proposed that 'world-class leadership talent and leadership development will exist at every level in the health system to ensure high quality care for all' ('*The changing role of managers in the NHS*' 2011). The need for this was reinforced by the multiple recommendations highlighted in the NHS by the 2013 'Francis Report', which advocated the creation of a culture which integrated essential shared values into all processes, the accountability of leaders and senior managers, and the enhancement of leadership recruitment, education, training and support.

Leadership from Board to Ward

The emphasis on leaders and leadership in the health sector is based on the necessity to deal with complex challenges and at the same time satisfy the aspirations of a wide range of stakeholders in meeting these challenges

(including patients, consumers of health services, the health workforce, regulators and financial stakeholders) such that 'effective clinical leadership at board level is essential and has never been more necessary' (King's Fund 2009: iv). But these aren't the only forces that have an impact on the quantity and quality of leaders. Additional factors are complex business models, such as multi-hospital healthcare systems, which have unique leadership challenges due to the scale of operations (McAlearney 2010), local or regional health leadership needs (Mansour et al. 2010), and the global nature of talent challenges. To deal with these forces will require clarity about what leadership in health is and how far into the organisation the concept extends.

There is some progress towards resolving this dilemma and particularly between the roles of leaders and managers. Given that the concept of leadership is complex and multi-dimensional and that no universally accepted definition or theory of leadership exists, there is increasing clarity about the overlaps and differences between leadership and management (Scully 2015). Lawrence and Richardson's UK study (2014) of the leadership experiences in an acute unit within the NHS found that local leaders did not follow a single leadership approach but in fact adapted the approach to their environment. Here, leadership was contextual and non-hierarchical, contained elements of what might be traditionally referred to as management and combined both into an effective single modus operandi.

Increasingly, leaders will be, for example, 'staff nurses who exert significant influence over other individuals in the healthcare team, and although no formal authority has been vested in them facilitates individual and collective efforts to accomplish shared clinical objectives' (Chavez and Yoder 2015: 90) or those at the point of care from where effective leadership has been shown to improve patient safety and satisfaction and decrease mortality (Wong and Cummings 2007) and those in devolved positions of leadership (with different types of leadership strengths) in all parts of the health organisation with evidence of multiple positive outcomes (Titzer et al. 2013: 972; Chan et al. 2015). Extending the concept of leadership in this way will require crafting if it is to be delivered effectively.

Health sector leadership will drive transformation and change, it will create a unifying vision around which the workforce can mobilise and it

will inculcate a culture of fairness and transparency, opportunity and engagement. But this is only one part of the leadership paradigm for health, and recognition that leadership takes place at all levels will allow a more holistic scope to both succession management and leadership development in a way that balances the needs of multiple types and levels of leadership practice. This will be necessary to satisfy the dual objectives of leaders to deal with leadership at the point of care as well as organisation-wide change and transformation.

These points of view highlight the fact that different health contexts, organisation structures and cultures demand different types of leadership moving towards the devolved and non-hierarchical. Indeed, the complexity of the health sector environment would favour leaders of different styles and temperament. These would include those with strategic vision and the ability to steer the organisation along a particular path on the one hand; and on the other with the ability to craft a strategy within complex environmental boundaries and subject to unpredictable forces of. In all cases, leadership in health will require personal insight, professional credibility and an understanding of organisational dynamics.

To date, much of the activity in talent management in health has been focused on those in the highest level of leadership, based on the view of the necessity of the right level of competent leaders as the organisation goes through periods of change. It is unlikely that a small group of high-level leaders would be able to deal with such a wide and diverse range of forces without leadership interventions at multiple levels. How this plays out in reality will determine how talent management can contribute to their recruitment, development, management and retention of leaders in the healthcare sector.

Defining Succession Planning in the Health Sector

In support of the identification and development of leaders, succession planning contributes to ensuring a sufficient quantity, with the right outlook and skill set and continuity in leadership for the organisation over time (Carriere et al. 2009; Baron et al. 2010; Griffith 2012: 901; Titzer

et al. 2013). This is a planned and systematic approach which frames succession planning in a range of leadership competences, traits or attributes and relates these to both organisational objectives and talent strategy.

In this context, succession planning in the health sector has been defined as 'a strategic process involving identification, development and evaluation of intellectual capital, ensuring leadership continuity within an organisation' (Titzer et al. 2013: 972) or as 'a deliberate and proactive process of identifying key, generally senior-level positions' which if became vacant would be detrimental to the organisation's performance (Kurec 2012: 23). For the most senior positions, identifying desired leadership competences was considered to be the foundation of succession from which to inform subsequent elements of talent management such as leadership development (Titzer et al. 2013); in other contexts, the ability to function as a leader and to influence and direct is important through to the point of care. Effective succession planning 'incorporates those actions, activities and interventions intended to ensure that capable, motivated and talented individuals are ready to assume the leadership roles for which they have been selected' (Griffith 2012: 901–902). Research has shown the positive effects of succession planning in health (Patidar et al. 2016). Organisations in the sector can use these results to make informed decisions about investing in leadership development programmes.

Distinct elements have been identified in the succession process (Carriere et al. 2009) which include strategic planning, its translation into skills and competences to achieve strategic goals, key positions and the selection of suitable candidates to fill them. Once this has taken place, talent management tools such as mentoring and coaching or other developmental activities are introduced and the final element of evaluation is put in place. Succession planning and its association with talent apply to a broad range of scenarios. In the first instance, there is a need to ensure that high-level leadership and managerial roles are fulfilled as well as key technical and clinical roles. The objective is to both develop and retain 'knowledgeable personnel to meet organisational needs' (Carriere et al. 2009). Succession planning provides the basis for determining the optimum mix of internal and external recruitment and the consequent level of leadership or management development.

Interpretations of the nature of succession vary among health organisations around the world from the process of identifying 'superheroes' (Day et al. 2014) to integrated succession planning for nurse practitioners (Rafferty 2013; Kim et al. 2014).

Succession planning is a process by which the organisation 'can manage the current workforce changes effectively as well as forecast and plan according to future human capital needs, such as when the organization grows, and build a talent agile culture to lead the way' (Martin 2015). It consists of a combination of development plans and talent reviews (Lamoreux et al. 2009) targeted towards a health sector unit or combination of units and is usually led by HR, OD or talent practitioners.

Case Study: A Comparative Study of the Development of Managerial Talent in the Health Sectors of Egypt, Mexico, Romania and the United Kingdom

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Good management and leadership produce good healthcare, whereas poor management and leadership generate poor healthcare (Borrill et al. 2004; Flowers et al. 2004; Michie and West 2002). But relatively little is known from contemporary empirical research about what differentiates effective healthcare managers from ineffective ones. The lack of consensus on definitions and theorisation of leadership behaviour and effectiveness has compounded this problem. A contribution to knowledge in the area of healthcare-related managerial effectiveness research has been made by a series of cross-geography studies based on the use of critical incident and factor analytic techniques on middle and frontline levels of management which have since been replicated within a 'specialist' NHS Trust hospital (Hamlin and Cooper 2007) and public hospitals in Egypt (Hamlin et al. 2010), Mexico (Hamlin et al. 2011) and Romania (Hamlin and Patel 2012). A recent cross-case comparative analysis of findings obtained from these inquiries lends strong empirical support for a healthcare-specific behavioural taxonomy of managerial and leadership effectiveness composed of a set of generic positive and negative behavioural criteria.

The emergent positive behavioural criteria include the following:

- Organisation and planning (e.g., good planning, organisation, directing, execution and control and effective problem prevention and resolution)

- Active supportive leadership (e.g., backs staff ideas, gives practical support when they are under exceptional pressure, and gives thanks and praise)
- Giving support to individual staff (e.g., listens to staff concerns/worries and handles personal issues sensitively)
- Open and personal management approach and style (e.g., gets to know staff as individuals, develops a sense of trust, and is readily available to them)
- Inclusive decision making (e.g., involves staff in discussions/decisions, consults with them, and seeks staff ideas)
- Looking after the interests/needs of staff (e.g., promotes the importance/needs of the department and its staff and actively addresses the learning and personal development needs of staff)
- Empowerment and delegation (e.g., delegates roles and responsibilities, gives staff freedom to make decisions, and encourages them to reconcile differences/work through problems with each other)
- Informing people (e.g., communicates regularly with staff and keeps staff informed on matters affecting them)

And negative behavioural criteria:

- Dictatorial/autocratic management (e.g., imposes decisions/change with no prior discussion/consultation, refuses to admit to own mistakes, and adopts an authoritarian style)
- Intimidating behaviour (e.g., exhibits threatening/bullying behaviour)
- Negative approach (e.g., emphasises negative views and is closed-minded)
- Undermining behaviour (e.g., is dismissive in dealing with staff, makes cutting/off-hand remarks, chastises staff in public, overrides colleague managers, fails to follow hospital polices/rules or by-passes systems, and exhibits manipulative/politicking behaviour)
- Avoidance and ignoring behaviour (e.g., refuses to recognise problems/deadlines, avoids making decisions, and procrastinates in taking action)
- Failing to inform other people (e.g., neglects to share with staff information or give advance notice on matters that will affect them and fails to impart accurate, reliable or up-to-date information)
- Not receiving or using information (e.g., omits to seek, use, or take into account the views/needs of staff)
- Exhibiting poor planning and organisation (e.g., acts before obtaining/checking the facts or thinking through the implications, gives insufficient to time to organising and administration, adopts short-term view and exhibits poor forward planning, and fails to prioritise)
- Self-serving and uncaring management (e.g., is inconsistent; fails to be open, honest, forthright or up-front when communicating; and is unfair/shows favouritism in dealings with staff)
- Lack of concern for staff (e.g., places unrealistic workloads or expectations on staff, is unwilling to address staff concerns, gives little instruction/

support in change situations, and denies staff opportunities for self-development)
- Abdicating roles and responsibilities (e.g., passes the buck, fails to monitor/take control of performance problems, and omits to provide adequate cover for foreseen staff absence)

Potentially, this universalistic taxonomy, once fully developed, would be useful in crafting an evidence-based approach to the development of managerial talent within the health sector.

The Links Between Succession Planning, Leadership Development and Talent Management

Talent management, succession planning and leadership development can exist in a series of bilateral relationships. That between talent management and leadership development, for example, is a process of challenge and response. A shortage of the skills necessary to deal with the organisation's current or forward leadership needs will prompt those responsible for talent management to design appropriate interventions (leadership programmes, secondments or executive coaching). When there is an abundance of skills, talent management will provide new ideas based on prevailing wisdom for how leaders should be developed and initiate programmes, will be the source of tools to assess potential leaders, and from these results will provide nominations to talent pools. Succession planning will have a similar bilateral interface with leadership development. Individuals will be nominated for key posts and their development set in train.

But there are limitations to this binary approach. For example, succession planning can be little more than replacement planning, matching names of candidates to high-level roles and responding to development needs of individual leaders in an ad hoc way. Or succession planning becomes an annual event from which the next year's leadership development needs are identified. Similarly, talent management may be viewed as a necessary process but without any sense of alignment to the organisation's purpose. The way to address these issues is through a more holistic approach in which there would be greater integration between the three

areas of talent management, leadership development and succession planning. Thus, talent management would be part of an organisationally aligned talent strategy; leader development would become leadership development and include more people at more levels within its sphere and would include organisational skills in addition to traditional leader competences. In this context, succession planning would become succession management.

The key elements of such an approach are included in Fig. 7.2.

There is evidence of this fresh perspective. In the US health sector, for example, there was integration between the institution's strategic plan, key positions associated with this, and career ladders designed to support people development into these positions. Employee profiles and talent inventory were all undertaken to 'identify education, talent, and experience, as well as areas that need improvement' (Ellinger et al. 2014: 369). Furthermore, research has shown that 90% of US executive leadership

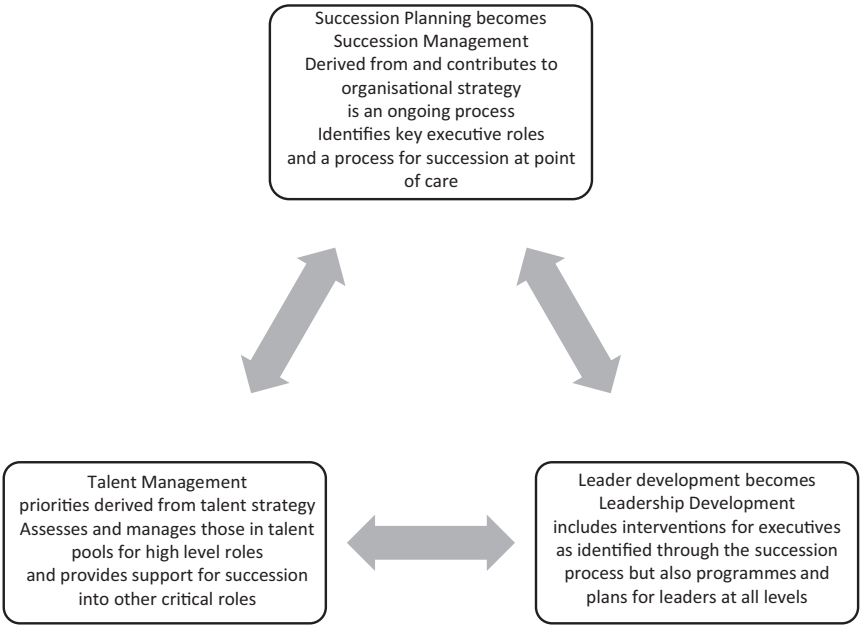

Fig. 7.2 An integrated approach to talent management, leadership development and succession management in healthcare

programmes surveyed were able to link such programmes with strategic goals (McAlearney 2010). The potential value is clear for greater coordination between talent management, leadership development and succession management. There will be benefits for both the individual (better understanding and alignment to the organisation's direction) and the organisation (better returns on its investment in people development). To bring clarity to such an approach, it is worth investigating how leadership in the health sector interfaces with talent management and how the two can be brought into succession management to form an integrated whole.

Amongst the elements of succession planning in health identified by Carriere et al. (2009) and Trepanier and Crenshaw (2013) were desired skills identification and the identification of key positions and candidates. These formed the framework for succession, whilst leadership development programmes, including coaching and mentoring, were the tools of implementation. Talent management played a critical part in defining the competences for succession (aligned to the organisation's objectives), the assessment processes in identifying which people would have the potential for succession roles, and developmental actions or programmes to address individual needs.

It is essential to reflect on the duality of leadership perspectives in succession management processes to ensure a supply of health sector leaders at all levels. This will require a transition from what we might call replacement planning to a more inclusive approach to succession. Indeed, it is increasingly recognised that talent management and leadership development are part of a wider system whilst both are critical to healthcare organisations. Programmes for succession planning are equally important (Satiani et al. 2014).

Succession Management in Place of Succession Planning

In spite of the considerable benefits, there are also some limitations to this approach. The most notable are that the process is normally targeted towards the most senior leaders in the organisation and that it is often a

stand-alone process. Integration with other operational, talent management or human resource practices can be piecemeal. To overcome these shortfalls, *succession management* has emerged. This targets all critical positions in the organisation, at all levels and in a way that is cross-organisation (as opposed to a single unit or department), aligned to overall strategy and utilising the full range of people management and development tools.

In the health sector, this has grown in prominence. In nursing, for example, global nursing shortages that have had a significant impact on healthcare make the adoption of succession management for roles at all levels a priority for nursing leaders (Griffith 2012). The challenge for health sector organisations is to ensure that they have succession management as part of their overall strategy-setting process and a well-thought-through set of leader and leadership propositions to provide candidates for succession posts. This is true on many levels. For example, the need for 'a deliberate strategy to ensure an adequate leadership pipeline among nurse managers has never been more apparent' in the USA (Titzer et al. 2013).

Succession management is becoming important to both strategic organisational governance and operational continuity in the health sector. It is argued that a formal succession management process is critical not only for financial and operational performance but also to sustainability (in, for example, acute care hospitals; Trepanier and Crenshaw 2013). Succession management is an integrated part of business strategy and planning 'that promotes effective leadership transition and continuity while maintaining productivity'.

Assessing People for Succession and Leadership Development in Healthcare Organisations

An important facet of talent and succession management is to identify those characteristics that would single out a particular individual for a leadership role and match a percentage of individuals in the organisation

against these competences, often in the form of a talent pool of people who have been chosen to fast-track into senior leadership positions. In this respect, traditional leadership selection and assessment have been based on the selection of leaders against competency frameworks.

The critique of this is that such a process assumes that organisations are driven by 'a single form of leader dominated rationality rather than social or emotional processes' (Grint 2007: 232). Too often the criteria for the selection of leaders are based on leadership theory rather than leadership practice. In fact, leadership is a complex, multi-faceted process and the translation of theory to practice is 'never simply a unilinear act of transmission' (Grint 2007: 233). Furthermore, Hlupic (2014) has argued that leadership is in transition from a traditional to an emergent style characterised by the distribution of formal power and decision making, the creation of interactive informal networks, and a learning mindset. As organisations become more complex, the greater the need for leaders who eschew a top-down ethos and move towards a direction that is derived from network activity, who use inspiration and intuition instead of toughness and control, and who are comfortable with adaptation through decentralised systems. Hence, the most effective leadership development is a mixture of theoretical input, tools and techniques and a reflective process of application.

Organisations in the health sector have adopted a variety of practices to assess and identify leaders though the competency-based approach to leadership assessment. This will assess leaders on the basis of their match to the competences (knowledge, skills, attitudes and behaviours) that will lead to superior performance.

A study of leadership performance against such competences was carried out in Asia by using an instrument known as AHEAD (Aspiring leaders in Healthcare—Empowering individuals, Achieving excellence, Developing talents). The study covered those from a broad range of professions, including dietetics and podiatry, and found a strong relationship between this approach and Kouzes and Posner's Leadership Practices Inventory (Ang et al. 2016). Furthermore, a competency model was used in the British health sector spearheaded by the National Association for Healthcare Quality, which undertook the development and validation of a competency-based model in support of healthcare leaders' assessment

of strengths which provided the basis for developmental interventions (Garman and Scribner 2011). In North America, the Healthcare Leadership Alliance proposed five competency domains for healthcare: communication and relationship management, professionalism, leadership, knowledge of the healthcare system, and business skills and knowledge to be applied to practitioner communities (Stefl 2008). In Finland, the Nurse Managers Leadership and Management competences scale (Kantanen et al. 2015) provided a self-assessment test against 194 items and divided competence into general competence and special competence. The instrument was used to evaluate nurse managers' leadership and management competences which would lead to developmental actions.

There is evidence of the use of a range of sophisticated assessment tools for leaders and managers in the healthcare sector around the world. The basis for most is a competency analysis creating domains of varying levels of depth and applicability. In some, as in nursing, there is commonality in these approaches. But this is not universal across the professions.

Leadership Development Practices

The importance attached to leader and leadership development is consistent throughout the healthcare sector on the basis of evidence that effective frontline clinical leadership can improve both clinical outcomes and patient satisfaction for patients and providers (Blumenthal et al. 2012). Leader development can be viewed as an intervention to improve the abilities of people to lead. It will consist of programmes to hone classic leader skills often based on well-structured competency frameworks. Three-hundred-and-sixty-degree feedback processes and executive or performance coaching may also feature (McAlearney 2010). But leadership development extends the process and includes more people for more roles (over and above the board or executive team) whilst having specific tailoring to suit the mission and objectives unique to an organisation or group of organisations (for example in a multi cultural context El Amouri and O'Neill 2014).

As well as including the skills required to run an organisation in an operational sense such as general management and finance, leadership

development might include developing an understanding in organisational dynamics (politics) and the process of guiding the organisation as a whole to its strategic targets through inclusion and engagement.

The importance of the strategic alignment of the leadership development processes of organisations in the health sector has also been emphasised. In their evidence-based analysis, Anderson and Garman (2014) concluded that this was essential for the success of any subsequent leadership development activities. This would be characterised by senior leadership involvement in the process and the leaders would act as mentors and learning facilitators. Clarification of the objectives of leadership development is an important criterion and where research has taken place on this subject in the health sector these criteria include the achievement of organisational goals but also developing the employees, improving the workforce, contributing to being the employer of choice, and showing a commitment to education, learning, training and development (McAlearney 2010).

There are richness and diversity in leadership development practices in the healthcare sector worldwide (Table 7.1).

- Executive leadership development programmes grew in North America from 2003 onwards (McAlearney 2010). They have become particularly popular in smaller health systems or groups of organisations. Research has shown that they have been successful in delivering programme objectives and sustained budgetary commitment.
- The creation of high-potential leadership programmes was prominent and these were found to be run through a centralised system of management (Anderson and Garman 2014), whilst nursing leadership development programmes and performance coaching were the least centralised.
- Leadership development has been focused on the growing number of physicians who are moving into leadership positions. Whilst they will have shown excellent technical skills, these may not be sufficient for the complexities of healthcare administration. Leadership development programmes involve training in 'interacting with unfamiliar constituencies, such as senior administrative leaders in nursing or finance, in the complex and continually evolving healthcare landscape'

Table 7.1 Examples of leadership development practices in the health sector

Succession planning and management	Leadership and management development programmes	Executive coaching, performance coaching and mentoring	Professional networking, projects and secondments
• Linking leadership development to health unit succession plans • Succession planning to ensure continuity of hospital business or operational leadership • Succession planning for nurse executives • Succession management directly linking development plans to overall talent management	• Strategic alignment of leadership development to organisational goals • Development of executives in multi-unit hospital systems • Development of frontline clinical leaders • Physician leadership development • Formal leadership training for specialist groups (e.g., radiologists) • Formal leadership training for health administrators • Leadership development integrated with high-performance teamwork • High-potential programmes for high-performing managers • Leadership development for point-of-care roles • Competency models to assess leadership candidates	• Executive coaching as part of leadership development programme • Career planning advice for healthcare executives • Mentoring for nurse leaders • Coaching and mentoring for high-potential employees • Understanding and developing emotional intelligence • 360° assessment processes for clinical leaders • Mentoring for a wide range of employees in a hospital environment • Development or assessment centres	• Sponsoring membership of professional organisations • Networking outside of the health sector to broaden perspectives • Job rotation • Cross-departmental projects • Organisation-wide projects (information technology systems and so on) • Stretch assignments

(Henson 2016). An additional element of understanding emotional intelligence, learning agility and 'learning about self' were also recommended for inclusion on the development agenda (Larkin 2015; Moodie 2016).

- Leadership development, where it is integrated with teams, can show significant results where it is applied to leadership at all levels and where it involves working with other teams in the health system (by providing a pathway to lead and manage to improve performance) (Morsi 2010).
- Leadership training for professional healthcare administrators in North America (Jackowski and Burroughs 2015) showed benefits in terms of focus, job satisfaction and the ability to inspire a shared vision.
- Increasing diversity can be enhanced by leadership development through effective talent management. In US healthcare organisations, for example, the 'lack of depth of women leaders' was identified as being both perplexing and challenging given the transformation that was taking place in the sector. The opportunity was presented because 'women, who make up the majority of the workforce in healthcare organizations are largely an untapped resource for many of the leadership gaps that will result from this trend'. The recommendation from the research was 'to provide the support and sponsorship necessary to develop women in leadership roles', creating a leadership pipeline with significant organisational benefits (Hauser 2014).
- Coaching and mentoring were common features of leadership programmes. In a study of North American leadership development, 86% of programmes involved the use of executive coaches (McAlearney 2010). Other examples include a one-year formal mentoring programme supported by physicians and management to develop those with potential to be future leaders in a rehabilitation unit in North America (Stuart and Wilson 2014). This included diversity in the choice of mentors backed up by a well-defined process for matching mentors and mentees and a formal programme to embed the process.
- Sponsoring membership of professional organisations to increase networking and the transfer of knowledge with networking opportunities

that would expose physician leaders to new perspectives (Henson 2016). Networking is a common feature of leadership development in healthcare and was identified as a characteristic of successful healthcare executives with the advice to have an extensive network that goes beyond the immediate clinical or professional expertise but is extended to people outside of the sector (Schlosser 2014).

- Support in career planning for healthcare executives (a survey showed that 12% of early careerists, 22% of mid-careerists and 49% of senior careerists had a career plan), emphasising that the traditional career ladder has been replaced by a career lattice, involving lateral as well as vertical career moves (Broscio 2014). To navigate such a career plan would require regular reviews and a career consultation process. The relevance of this is that 'an increasing number of physicians are embarking on a pathway from clinical practice to senior healthcare leadership positions that historically have been held by seasoned nonmedical or allied health professionals' (Henson 2016).
- There were examples of developmental experiences such as 'cross-departmental or system-wide performance improvement initiatives, participation in special projects such as building projects, enterprise-wide IT implementation, or fundraising campaigns, or even full-time rotation into other positions to provide exposure to different parts of the organization and/or system' (Anderson and Garman 2014).

In the future, if the above assumptions about the devolved nature of leadership in the health sector are accepted, leadership development will be not only about high-level programmes for those at the top of the organisation (though these are still critical to success) but also about a broad range of developmental activities for those in leadership positions at the point of care and elsewhere in health sector organisations. Where such an approach has taken place (as in the case of nurse leaders in North America), the results of development activity showed increased self-confidence, positive changes in leadership styles, and a broader appreciation of environmental issues within the practices within which they worked (MacPhee et al. 2011).

Conclusions and Implications for Practice

The above analysis shows the importance of talent management in the processes of leadership development and succession management. The move from a series of bilateral relationships between the three areas into an integrated holistic model was identified to ensure integration from point of strategy to point of care—from board to ward—in a way that is sustainable (through leadership development) whilst providing continuity (through succession management). To achieve this goal has implications:

- It is important for the healthcare organisation to have a clear definition of what is covered by the term leadership. If this is something that applies to the leaders who are at the apex of the organisation structure, then this has implications for the priorities and processes of both talent management and leadership development. If, on the other hand, a non-hierarchical view of leadership has been adopted, then the greater number of people will be included within the boundary and a range of leadership development solutions will be required.
- Subsequently, the opportunity to ensure an integrated approach to talent management, leadership development and succession management will be possible. Developing clear linkages between the three areas is an important activity. This involves ensuring that succession management is aligned with the organisation's goals and that leadership development is focused on the needs identified in this process and having the talent management tools and techniques that are relevant, fit for purpose and provide measures of the outcomes of developmental interventions.
- There is the possibility to move from replacement or succession planning to one of succession management. This will regard succession as less of a phenomenon and more of an ongoing activity. It also implies that succession 'planning' starts at an earlier stage than the traditional process of one-off ad hoc responses. Succession management can be a process that covers the whole of the leadership life cycle and can apply to greater numbers than those who are being developed for the most senior positions (although activity in the latter area remains mission-critical for most organisations).

- There is evidence that combinations of leadership activity will be effective. Thus, organisations in the healthcare sector match leadership programmes with coaching, combine leadership development with secondment or project opportunities and are creative in the use of mentoring as a tool for both leadership and management programmes.

Talent management has a key role to play in the integration process between succession management and leadership development. It acts as a recipient of intelligence from the organisation's strategy, its people strategy and its strategic workforce plan and is a provider of solutions (leadership programmes and interventions).

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8

Whole Workforce Development

Learning, Training and Development Throughout the Whole Organisation

An exclusive approach to talent management with a focus on developing executives and senior managers will impact on strategic direction and the ability to deal with transformation and change. But the challenge remains as to how to convert strategy into health organisation practice through a fit-for-purpose health workforce. Such an objective can be achieved through a more inclusive and pluralistic approach to talent which engages a broader group of employees to ensure that both strategic and operational initiatives are underwritten by capability at the point of care. This is referred to as whole workforce development and benefits a majority of stakeholders within the organisation (Bennet and Alliex 2014; Farndale et al. 2014; Saadat and Eskandari 2016) because it can be used to support the achievement of both organisational and individual aspirations, both of which are consistent with World Health Organization (WHO) objectives of transforming and scaling up training to increase both the quantity and quality of health professionals (WHO 2013: 8). It might be defined as follows:

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> Whole workforce development concerns the learning, training and development resource and activity required to build a fit-for-purpose health workforce with the right competencies needed to deal with the goals, objectives or priority issues in each organisation in each geography served by the health unit or group of units.

This type of development bridges the gap between societal or organisational goals, the scale and scope of which are established by identifying the skill mix that is needed to deliver health service in a particular region or area (*British Journal of Healthcare Assistants* 2016; Palsdottir et al. 2016). It is a continual process (Kol et al. 2017) aligned to the organisation's needs on the one hand but supporting educational and career development for all on the other (Fig. 8.1). Whole workforce develop-

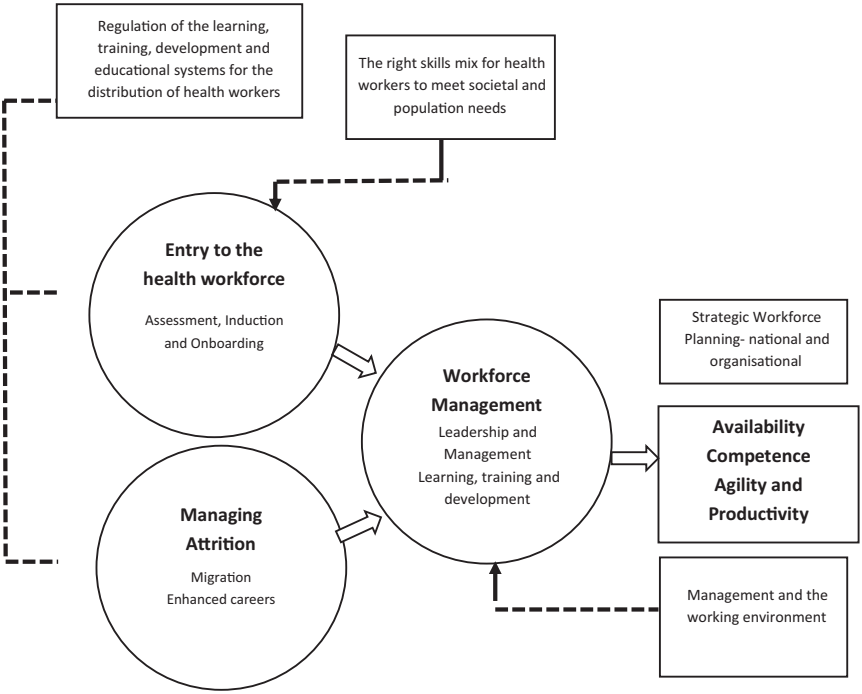

Fig. 8.1 Stages of health workforce development based on a World Health Organization model. After WHO (2006)

ment is an essential part of talent management in health because it can help to prepare for the rapid changes that are taking place in the sector (Pool et al. 2013).

The Perceived Benefits of Whole Workforce Development

At the organisational level, whole workforce development means having the right learning, training and development tools in the right place at the right time in the right way to meet the needs of the majority of the workforce and the organisation. There is much support for this view, and developing the knowledge and skills of healthcare employees is 'front of mind for many healthcare employers as they face talent shortages and high turnover. And skills development is increasingly important as the critical services and responsibilities of healthcare teams expand in volume and scope. To keep pace with that expansion, healthcare organizations—from small, community-based facilities that deliver outpatient services, to acute care hospitals with thousands of employees—are investing in training' (Ho 2016). Whole workforce development increases the 'supply side' of the health labour market (McPake et al. 2013) and can have positive effects on both the organisation and nationally.

Once again, best fit will inform the positioning and direction of whole workforce development, and where it is implemented successfully, the potential outcomes can be significant (Didem and Zumrut 2014; Dailey et al. 2015). These include the following:

- 'lower patient mortality, lower complication rates, shorter length of stay in hospitals and may lead to lower costs by avoiding the costs of poor quality' (Squires et al. 2015: 2);
- access to training, the frequency of training, the motivation to learn from training, and the benefits of training were positively related to employee commitment (Bartlett and Kang 2004);
- evidence that links whole workforce development to high-quality services to patients by complementing the development of specialists in

all health professions with the development of direct care workers as central members of the team (Warren et al. 2015; Ramadevi et al. 2016; Dawson and Langston 2016);
- whole workforce development can bring diverse groups of people together in mobilising networks of community resources (Tobin 2013) which can translate to excellent performance.

The focus on this issue is critical since 'effective workplace learning in healthcare industry is crucially needed in ensuring better services are provided to patients' (Saidi et al. 2014: 150).

To do so will require an environment where individual members of the organisation understand the knowledge, skills, attitudes and behaviours required to perform their current roles and those needed to advance their future careers and the creation of a culture of learning and access to the means through which such learning can be acquired; it is exemplified by both support and resources for development from executives and managers and can facilitate greater diversity, inclusivity and fairness.

External Influences and Human Resource Development

Two important factors have an influence on how an organisation in the health sector approaches its workforce development. The first is the context or environment in which decisions are made and priorities identified; the second is the conceptual acceptance of human resource development (HRD) as a principle within the organisation as outlined in the talent management evolution matrix.

In the first of these, workforce development decisions are influenced by macroeconomic or socio-political factors on the one hand and the specific needs of an organisation in its own regional context on the other. Examples of the former include the position in Oman, where a shortage of physicians and nurses was dealt with by a combination of strategic workforce planning at the governmental level and national policies with respect to training and development to ensure self-reliance rather than depending on expatriates (Ghosh 2009), or in Australia, where a framework for work-

force development and processes was developed to guide the implementation of area health service strategies (Conway et al. 2006). An example of the latter, organisational context was in The Netherlands (Hino et al. 2011), where the availability of training opportunities and professional development of nurses in district hospitals contributed to positive perceptions of the work environment and reduced intentions to leave.

However, there is still work to be done in this acceptance because training and development can be long and expensive for health professionals. Furthermore, there are the issues of fiscal restraint, a reality in most healthcare organisations; under-investment in some areas; and a misalignment between health systems and the needs of the population (Gehrs et al. 2016; WHO 2016). To overcome these challenges, whole workforce development requires an emphasis on planning (Ansah et al. 2015; Pavolini and Kuhlmann 2016: 663), a health education curriculum aligned with local health needs, fit-for-purpose development where career tracks are designed to meet the needs of the communities served, workforce development aligned to gender and social empowerment, and inter-professional training with a sharing of good practice and resource (Palsdottir et al. 2016: 1).

In the second of these influences, whole workforce development can be viewed within the construct of HRD, the definition of which (Gold et al. 2003) is still being addressed by both practitioners and academics. McGoldrick et al. (2001) argued some years ago for the multidisciplinary nature of HRD building on the process of increasing knowledge and skills and bringing learning into an organisational context. More recently, Sadler Smith has put forward the view that HRD research may 'contribute usefully to … systems of management that are better fit for purpose than those which we currently have' (Sadler Smith 2014: 130). In reviewing the multiplicity of interpretations and definitions, Hamlin and Stuart (2011) identified four key 'purposes' of HRD and these provide the foundations on which workforce development for health might be viewed. The four purposes are improving individual or group effectiveness; developing knowledge, skills and competencies; enhancing human potential and growth; and improving organisational effectiveness. Within these four are elements of leader and leadership development but also development within the wider employee population.

In order to establish a contemporary focus in these areas, a study was undertaken of one hundred mostly global, commercial organisations (Turner 2016) on how such organisations defined and prioritised their HRD efforts and resources. Table 8.1 shows the findings of this study in each of the four areas.

Table 8.1 The four core purposes of human resource development and their application in commercial and health sector organisations

Core purposes of human resource development	Analysis of 100 global corporations	Analysis of sources relevant to healthcare organisations
1. Improving individual or group effectiveness	Growth of coaching and mentoring Emerging talent Senior management training for succession Capability and CULTURE Use of non-formal training-networking, projects Diversity and inclusion Learning technologies as an online global talent resource	Leader and leadership development Leadership and transformation Management development Professional development Clinician leadership The importance of teams and team development in health
2. Developing knowledge, skills and competences	Localisation of talent Career progression	Coaching and mentoring Continuing professional development Clinical practice Competences of healthcare leaders The value of training and development in health
3. Enhancing human potential and growth	Diversity and inclusion Workforce representative of societies in which operations are taking place	Principles, care, morals and ethics Extending the range of those with health skills to improve access Learning collaboration

(*continued*)

Table 8.1 (continued)

Core purposes of human resource development	Analysis of 100 global corporations	Analysis of sources relevant to healthcare organisations
4. Improving organisational effectiveness	Connections (e.g., strategic workforce planning and people development) Global learning, training and development; global consistency; mobility of talent across geographies Talent management/people development frameworks Academies and corporate universities Succession management/talent pipeline Measures of effectiveness of learning, training and development	Change management-leaders as champions of change Workforce effectiveness Talent management Succession management Public and private health sector organisations Evaluation and measures of effectiveness Recruitment of talent Dealing with new models of healthcare Consistent standards of registration for health sector professional groups Workforce planning and impact on human resource development

This analysis shows that in commercial non-health organisations there was an emphasis on leadership and executive development. This is unsurprising since there is a need to reassure shareholders that continuity would be maintained if one or more executives left the organisation, hence the focus on succession, emerging talent, talent pipelines and diversity and inclusion at the board level. However, there was also a good deal of emphasis on the need to develop the knowledge, skills and competencies of the whole workforce, providing career progression pathways and ensuring that the use of technology for development is extensive and can be accessed by many. Diversity and inclusion throughout the organisation are also strong foci for development as well as building measures of effectiveness so that the organisation could

identify whether its investment in learning, training and development was cost-effective, although there were a variety of measures, from number of training days per employee to amount invested in financial terms.

When applying a similar methodology to analysing the priorities and foci of health sector organisations, derived from evidence in academic and practice journals concerned with human resources for health, there were some similarities to those of commercial organisations, as shown in Table 8.1. But there were also important differences. The health sector priorities identified for whole workforce development can be summarised as the following:

- There was an almost equal level of attention given to individual and organisation effectiveness.
- Strategic issues around the subject of succession were important. But, in contrast with the study of global commercial organisations, succession was not confined to the main board but was an issue below the executive level. Additional research is needed to establish why there is such a focus, but a related issue would be difficulties in recruitment, another prominent subject in the analysis. If there are shortages of talent to fill key roles from outside of the organisation, then internal development of potential succession candidates was a viable, if not the only, option.
- There was a strong emphasis on leader and leadership development applying to those at not only the very top of the organisation but leadership positions throughout health sector organisations.
- Continuing professional development was a prominent characteristic across the professional boundaries.
- The concepts of principles, ethics and morals were extremely strong in the health literature.
- Change management and transformation were also in evidence as areas for development opportunity and this is related to the significant amount of change that is taking place in health in almost every territory.

A Passion for Whole Workforce Development in Health

The literature on workforce development in the health sector is extensive and covers, inter alia, the value of training and development (Hernandez and O'Connor 2010); strengthening nursing and midwifery as a profession (Ventura et al. 2015); strengthening nursing education (Wong et al. 2015); physician training (Satiani et al. 2014); developing the right health skill mix (Buchan and Dal Poz 2002); conceptual frameworks and national plans (Conway et al. 2006); the use of coaching and mentoring (Subramaniam et al. 2015); the effect of training programmes on the work of general practitioner-based healthcare assistants (Weir 2015); and capacity building for sustainable health (Squires et al. 2015).

In nursing, continuing education, defined by the WHO as the process that includes experience after initial training, allows health professionals to maintain and increase skills consistent with their roles and, as individuals, is a key means of developing potential (Ferreira et al. 2013). There are efforts to align healthcare training systems to developing professionals orientated to globally integrated health human resource labour markets although in some professional areas there is little international standardisation (Foo et al. 2016: 665).

Furthermore, as health workers around the world take on new roles (nurses performing tasks that were previously undertaken by doctors, for example, and community health workers and nursing assistants developing new skills), the concept of whole workforce development becomes critical to success (Crisp et al. 2012).

There is clearly a passion for whole workforce development in health. The UK health sector, for example, spends more than £2.9 billion on education and training each year (Close 2014).

The transformation in the delivery of healthcare in different ways in different countries brings with it the necessity to ensure that whole workforce development is best fit to respond. One such way is the increase in collaboration between different health sector providers bringing the benefit of learning that is two-directional and maximises

the benefits of interaction with other international medical education collaborators (Kaddumukasa et al. 2014). An observation of changes in the US medical system could apply in many areas when it was noted that new emerging models of healthcare delivery and their implications for practice 'will require that primary care doctors act in teams with a range of other providers in caring for individuals, communities and populations. To be successful, these teams—composed of physicians, nurses, behavioral health specialists, pharmacists, medical assistants, and others—will need to know how to work together in an integrated, coordinated, seamless fashion' (Borkan 2013: 22).

At a national level, the WHO has outlined how the process might evolve, as shown in Fig. 8.1. In this model, whole workforce development takes place throughout the employee life cycle with relevant interventions from entry onwards with the strategic objectives of availability, competence development, responsiveness to need, and increases in productivity. Furthermore, the richness of academic and practice output in the health sector is matched by that of the passion for development: 'the training of nurses and midwives is fundamental, as these professionals are present and active in health care, whether in the suburbs, cities, rural communities, refugee camps, war areas, hospitals, primary care units, or homes' (Beck et al. 2013).

Applicability, Accessibility and Alignment

In each case, learning, training and development opportunities for those outside of the executive or managerial population contributed to positive outcomes for the country, region and organisations concerned. The argument for whole workforce development is that it can have an impact on the ability of an organisation to achieve its overall goals and objectives and on individuals to achieve theirs. The questions to be considered are does the theoretical definition of whole workforce development convert into practice, which people in the health sector are covered by the boundaries of the term, and what are the systems and processes that make for success?

In this respect, whole workforce development can be seen through the prism of the definition outlined above but has some unique contextual applications. In effect, it is that activity that takes place in an organisation to link healthcare employee learning and development to human resource activity and then aligns both to the achievement of health sector organisational goals and objectives. The platform can be based on the need to respond to a particular issue (nurse shortages or high turnover, or health organisation transformation and change) or can be seen through the need for greater alignment with the outcomes of organisational strategic or workforce planning, performance management and career development (Social Care Institute for Excellence, Workforce Development 2016 http://www.scie.org.uk).

In both the generic and specific definitions, effective whole workforce development goes beyond the provision of single training interventions. Alignment with the overall direction and goals of the organisation, continued consultation and support following programmes or workshops and 'congruence between the training content and practitioner experi-

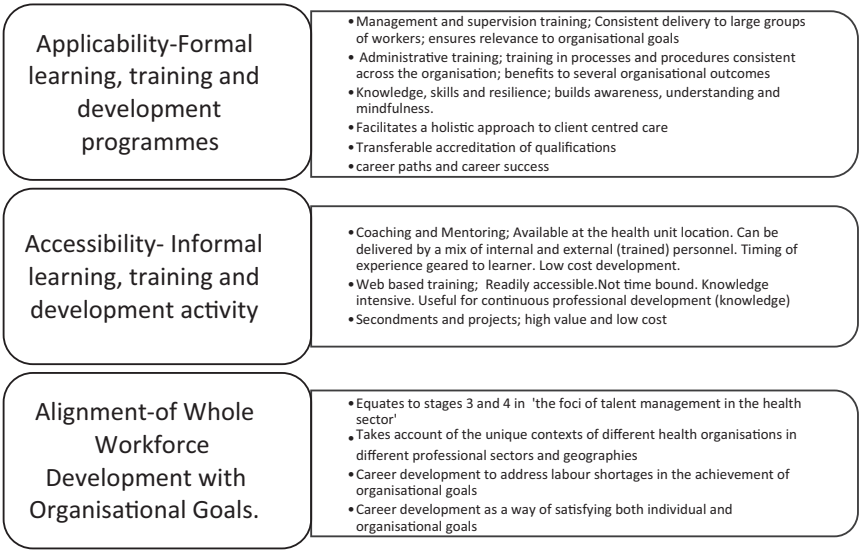

Fig. 8.2 The key components of whole workforce development in the health sector

ence' (Lyon et al. 2011) are important if most benefit is to be derived for both the individual and the organisation. This conclusion may be summarised as applicability, accessibility and alignment. Figure 8.2 shows how these apply to health.

Applicability—Knowledge, Experience and Resilience

Applicability is important because of the need to ensure that any development activity is relevant to the needs of both the individual and the organisation and can be shown as such. But the absence of consistently applied methodologies or the variation in measures of effectiveness that are a feature of this area makes assessing the applicability of any development interventions particularly challenging. Nevertheless, there have been several excellent studies in measuring applicability. Kirkpatrick's methodology (1977 and Kirkpatrick 2010) for training evaluation has been a popular, though not exclusive, method.

In Australia, the applicability and effectiveness of health short courses used a variety of assessment methods, including 'participant learning outcomes, intentions and confidence to use their newly acquired knowledge and skills; participant use of knowledge and skills gained; and participant perception of organisational support required to implement participant learning outcomes'. Kirkpatrick's (1977) training evaluation methods were taken into account in the process from which the implications for design of future programmes were identified (Naccarella et al. 2016). Whilst in the UK, midwife training was evaluated over time, finding that knowledge, confidence in communicating, and confidence in delivering diagnoses were improved (Bryant et al. 2016). In Ireland, an adapted Kirkpatrick model was used to evaluate nurse manager training (Dunne et al. 2015).

But applicability is measured in other ways. A Swedish study found that participant experience in a health programme could be categorised in terms of increased awareness, knowledge and understanding; influence on attitude and approach; and confidence. However the main finding was in

favour of ensuring practical focus and use. Applicability was high on the agenda of the participants (Svensson et al. 2015). Measures such as the Career Success Scale (Li et al. 2014) could be useful for nurse leaders in designing career paths and development programmes. A synthesis of some of the methods for assessing applicability is included in Fig. 8.3.

The foundation on which it is built are clear objectives for both the organisation and the individuals involved in the activity. In the absence of these, the development activity, whilst motivational at an individual level in the short term, may be spurious over the long term. With set objectives, the assumption of best fit will apply once again. Amongst the questions to be asked are who are the target audiences for the development,

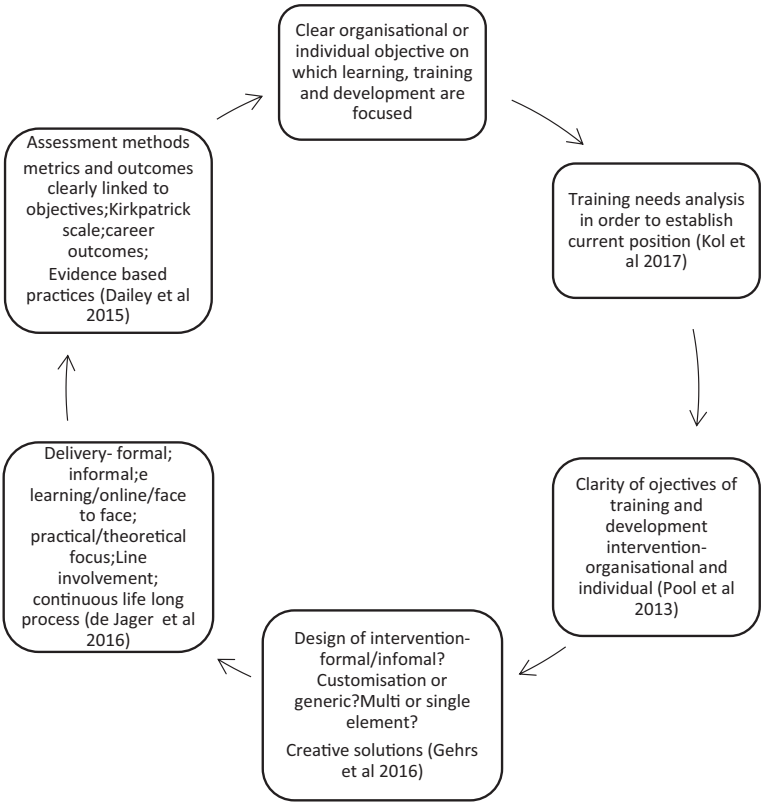

Fig. 8.3 Methods for assessing applicability in workforce development

what types of approach are likely to fit in with the culture and mores of the organisation, what resources are likely to be made available from which the design of the activity will be funded, and how engaged are managers in the development activity? Answers to these will inform the design of the development, how it is delivered, the key stakeholders, and what metrics will be necessary to assess outcomes.

There are variations on this process in the health sector worldwide. Because of different perspectives and priorities in education for professional nurses and midwives, the WHO has made recommendations about qualification, training, and the development of programmes that will enable nurses and midwives to deliver effective services according to the requirements of different countries (Ventura et al. 2015). Recommendations include training in the social and preventive aspects of modern health work, improving nursing and midwifery knowledge, integrating nurses and midwives into multi-professional teams, and educational programmes to pursue the health for all agendas (Ventura et al. 2015). This will inform both the objective setting and training needs analysis part of the process and influence design.

Increasingly, evidence-based nursing is the foundation for knowledge transfer. In China, such training is undertaken in line with the development of an approach focused on client-centred care and a holistic approach at the preventive, curative and rehabilitative levels (Wong and Zhao 2012), consistent with a macro-level training needs analysis which will influence the design and positioning of the programmes such as structured accreditation for professional healthcare workers and interdisciplinary education (Weir 2015; Boltz et al. 2013) into such programmes for positive outcomes.

The design and delivery of programmes have come under scrutiny in the applicability process and there have been creative ways to ensure that the critique of formal programmes (i.e., that they are too knowledge-focused without taking account of the context of healthcare) is addressed. Student nursing programmes, for example, have emphasised that placements (in the general practice or community) enabled students to develop a greater understanding of the things that are difficult to teach formally, namely complexities of care, how to manage risk and how to deal with unpredictability (Arnott 2010), whilst postgraduate residency

designed to expose trainees to inpatient, outpatient, and community-based care delivery once again delivered benefits (Miller et al. 2016). An engaged scholarship approach proved to be successful in combining formal academic learning with community-based action research (Stuhlmiller and Stolchard 2015). In Brazil, initiatives in 2007 had the goal of transforming health services by a process of teaching–learning through working that offered greater accessibility to health professionals (Furlanetto et al. 2015), whilst in Nepal, experiential learning proved to be useful in addressing potential gaps in medical education, especially where resources are constrained (Dhital et al. 2015). Several applications have been brough about as a result of e-learning. These include videoconferencing for clinical oncology, medical physics and radiology; digital self-learning modules; Moodle e-learning platforms; virtual learning centres; and synchronous classroom conferencing (Frehywot et al. 2013: 8) and are particularly diverse in India, Ghana, Natal and Malaya inter alia.

The subject of applicability has attracted a good deal of attention and as resources become stretched in the health sector this is likely to continue. Nevertheless, there are many excellent examples of health sector programmes in the whole workforce development approach that have proven to be applicable and have adapted to the changing context to ensure that they remain so.

Case Study: Building the Resilience of Healthcare Talent as Part of Whole Workforce Development

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Healthcare work can be stressful, even for its most talented individuals. Amongst the causes are workload, limited resources, conflict, psychological and physiological demands, job-insecurity and limited social support (Smollan 2015). To mitigate some of these factors, those responsible for human resources and talent management in healthcare are seeking ways to develop and increase the resilience in the workforce to ensure the success of talent now and into the future (Hardacre and Keep 2011). This is a growing area of interest and requires two interventions: first, defining what resilience means to talented individuals; second, identifying talent management processes to ensure that resilience forms part of their development.

Definitions of personal resilience often use the metaphor of 'bounce back' from adversity to one's original state (Tugade and Fredrickson 2004;

Tomassini 2015). However, researchers also argue that resilience moves beyond bounce back and that it involves a personal learning experience resulting in an effective and sustainable adaptation that transforms an individual into a new, positive and evolved state. This is sometimes referred to as 'bounce forward' (Zautra et al. 2010; Southwick et al. 2011; Flint-Taylor et al. 2014; Rajan-Rankin 2014; Tomassini 2015).

Nevertheless, there are challenges associated with defining personal resilience. Henning (2011) and Southwick et al. (2014) state that resilience can be defined only by each unique individual on the basis of their distinctive life experiences and subjective personal perspectives. They argue that resilience cannot be generalised and needs to be contextually explained. In their review of resilience literature, McAllister and McKinnon (2009) support this subjectivity, emphasising that wider social and cultural contextual factors impact upon an individual's personal resilience.

Exploring this further, personal resilience can sometimes be described as a recovery 'process' in response to an adverse event (i.e., an 'output'). Alternatively, it can be argued that it is an innate set of personality 'traits' that individuals have that enable them to protect themselves against adverse situations (i.e., an 'input') (Fletcher and Sarkar 2013; Flint-Taylor et al. 2014; Southwick et al. 2014). The personality traits of 'extroversion', 'agreeableness', 'openness' and 'conscientiousness' have been linked to increased personal resilience. However, caution is also called for in this area of research because of the complex dynamics between personality and the subjective nature of resilience (Shakespeare-Finch et al. 2005; McAllister and McKinnon 2009; Flint-Taylor et al. 2014).

Whilst resilience is certainly subjective and potentially unique to each talented individual within the healthcare workforce, there are generic ways to help healthcare talent to become increasingly resilient and, in turn, to reach their potential more rapidly in supporting healthcare business.

Healthcare organisations can support the development of a resilient workforce by considering ways to provide both social support and time for inner reflection and personal growth. Such developmental activities may include the following:

- Providing access to social communities and support networks as part of whole workforce development (Wicks and Buck 2013; Rajan-Rankin 2014; Southwick et al. 2014). This should include emphasis on building cohesive teams who understand and appreciate one other and how to maximise their social support network.
- Working with talent to embrace uncertainty to learn about themselves, (re)construct their self-identity and personally develop from their life experiences. This should include ways to help individuals understand their personality and how they respond to stressful situations

(Shakespeare-Finch et al. 2005; McAllister and McKinnon 2009; Flint-Taylor et al. 2014). Coaching is an ideal talent development space to achieve this.

- Developing healthcare talent to reflect naturally upon their practice and grow as a result of their life experiences offers an essential element in helping individuals to reach their potential more quickly for our healthcare business. The practice of 'mindfulness' and becoming more aware of how one's mind works through reflective practice is an increasingly popular way to enhance personal and organisational resilience (Wicks and Buck 2013; Rishel 2015). In addition, ensuring that workforce development activities include time for self-reflection will allow individuals to enhance their personal resilience through 'inner transformational learning'. Doing this will assist in developing personal identity and self-understanding, which are pivotal factors in enhancing personal resilience (Rajan-Rankin 2014; Tomassini 2015).
- Identifying the importance of seeking out and reflecting upon personal feedback will enable individuals to gain personal insights and in turn assisting them in enhancing their personal resilience (Henning 2011). The use of 360° feedback or similar approaches in all talent development activity will help to develop the self-insight and personal resilience of the entire workforce.
- Encourage increasingly challenging tasks and stretch assignments as a core part of the talent development strategy. Fully support these talented and aspiring individuals as they embrace such developmental situations to step up and challenge their performance, with an emphasis on a strong support network should they encounter situations beyond their current personal ability to cope with this added stretch (Turner and Nichol 2016).

These activities are designed to be part of a complete workforce development strategy to ensure support to continually enhance the personal resilience of the entire workforce. This in turn will enable healthcare talent to perform at its peak potential, deliver gold-standard care, and continually thrive in an industry that faces constant change and transformation.

Accessibility—Innovation and Responsiveness

If the worldwide shortage of healthcare workers is to be addressed, there needs to be accessibility for greater numbers of people to opportunities to learn train and develop. If there is a tightening of border controls which prevents the relatively free flow of health talent throughout the world, then the onus will shift to national, internal development. Accessibility

will be of paramount importance in addressing the training of healthcare workers. When wide-scale learning opportunities are provided, such as when e-learning is available and accessible for health workers in low- and middle-income countries, this not only can provide valuable skills but also could alleviate shortages of healthcare workers and improve retention rates (Frehywot et al. 2013). The application of whole workforce development can address the quantitative challenge of not enough professionals and the qualitative challenge of not enough professionals to deal with the complexities of contemporary healthcare. Accessibility refers mainly to the ease of access for the majority of the workforce to development opportunities and to the content within the programmes or interventions.

Evidence shows that accessibility varies from country to country and organisation to organisation. In a cross-sectional study of Indian hospitals, for example, doctors were found to have the greatest access to learning opportunities and hence the greatest opportunity to upgrade knowledge and personal development through education programmes and conventions. In the same study, paramedics had the least opportunity for formal programmes and so developed through collaboration and learning from each other (Kumar et al. 2016). The challenge therefore is to improve accessibility to the traditional approach to development, making it more readily available to the numbers of people who fit the healthcare worker profile within the timescales of the anticipated shortages and in the places that are most affected. Where this is not possible (through a combination of geography, time constraint and cost prohibition together with the lack of standards and methods of development that can be applied globally), innovative ways of improving accessibility of development need to be introduced.

The previous section outlined how those designing formal programmes had adapted the proposition to overcome any perceived barriers. Hence, the inclusion of experiential or practice-based development to complement essential knowledge transfer. The same level of responsiveness is also in evidence in the less formal aspect of development. Indeed, the pressure to deliver has brought with it regional and local innovations. These range from low-cost one-day training packages to reduce maternal mortality in Sub-Saharan Africa (McCarthy et al. 2015) to appropriate ‘e’ or

distance learning to provide 'unique, timely, cost effective, easily scalable and valuable opportunities to expand access to training manpower in developing countries where the shortage is critical' (Emmerick et al. 2014; Dawd 2016). Furthermore, the use of collaborative fora facilitated by online collaboration has proven to be a cost-effective way to ensure greater accessibility to learning training and development. Examples of success in this area include an innovative, international online discussion forum between students in Australia and the UK working with children and families which produced three main areas of learning, namely the differences across locations within countries, the need to respect different views, and need for continued learning for future development (Price et al. 2015).

E-learning and learning through social media offer a utilitarian approach to the accessibility of learning in whole workforce development or a means to inclusive professional development (Lawson and Cowling 2015). And yet the evidence to date is mixed. An Australian study revealed the benefits of social media-based learning, including the contemporaneous nature of the information, the speed of delivery of the information, and the ability to tailor the format of the information to the needs of individuals. But there were also barriers to learning, including the credibility of the information being presented and the possibility of misinterpretation. The study found that the majority of participants preferred formal e-learning programmes to the looser social media applications of learning (Kitching et al. 2015). This point of view was reinforced by research in primary care in Sudan, where the formal medical qualification was supplemented by e-learning, including online lectures which were highly rated by candidates on the programmes (Mohamed et al. 2015). In the UK, healthcare employees who completed an e-assessment and undertook an e-training programme showed the benefits not only to their competence set but also to their working life and well-being (Nilsson and Engstrom 2015).

Greater accessibility through such processes as online inter-professional education can create collaboration in learning. It can develop collaborative inter-professional capabilities and a client-centred approach. Research has shown that where this was implemented successfully it was able to meet immediate complex client needs (Cartwright et al. 2015)

and at the same time provide development of a future workforce with collaborative mindsets.

Finally, coaching and mentoring provide those involved with whole workforce development in the health sector the opportunity to deliver developmental interventions in the place of work and hence increase accessibility. Research has shown that when applied to the development of trainee doctors in public hospitals, both were positively associated with talent development. Indeed, it has been argued that mentoring has become a significant part of professional life in several healthcare professions (Gopee 2015; Subramaniam et al. 2015).

Accessibility then is an important part of whole workforce development. The success of a development intervention is due only in part to its design and the fact that it meets both organisational and individual needs. Neither of these will be of any use unless people can access them with ease and in a way that suits different learning styles. These are fundamental points in whole workforce development.

Alignment of Whole Workforce Development with Organisational Goals

The alignment of workforce development goals with organisational goals is important as healthcare organisations make decisions about where to allocate scarce resources. The tacit benefits of investing in the workforce (more skilled employees providing better care and more engaged employees perceiving the opportunity for career development as in the case of excellent progress in neonatal nursing in the UK (Jones and Ashworth (2016)) have been sufficient for organisations to provide training and this will continue to be the case. There is a moral and ethical case for such investment. However, the case for how much, where and when are more open to discussion. Therefore, the closer whole workforce development is to the organisation's goals (one of the four purposes of HRD discussed earlier in this chapter), the greater the case for why investment should continue and at what level. This is a topical area in the health sector where increasing demand for health services is matched by shortfalls

in supply and a need to provide more trained workers to deal with the position.

At a policy level, the alignment between whole workforce development is achieved by using a variety of data sources to create knowledge from which sustainable policies towards the health workforce can be created. Pavolini and Kuhlmann's (2016) cross-geography study of professional development trajectories (for doctors, nurses and care assistants) in different types of healthcare system (Germany, Italy, Sweden and the UK) found that there were in fact country-specific, uneven experiences of professional development which could be used to inform workforce development in order to address issues of skills mix. Other interventions on the subject of alignment of the whole workforce development goals with those of the organisation include the importance of creating community-appropriate workforce development programmes aligned to identified need, as in the case of New Orleans health workers (Wennerstrom et al. 2014), and taking a strategic management perspective, with a balanced scorecard approach which has been offered as a way of monitoring and guiding the alignment. Research has shown that the balanced scorecard provided a useful source of cause-and-effect relationships, 'turning the functional training efforts into strategic results', whilst supporting those responsible for delivering training and development activities a means of targeting their resources to match those required to achieve organisational outcomes. Furthermore, the research showed that the balanced scorecard offered critical measures of evaluation which could once again be used for aligning objectives (Baraldi and Cifalino 2015).

The links between curriculum development and organisational expectations have also shown the benefits of demonstrating an alignment between the two. In the Greek health sector, workforce development interventions, working on the assumption that programmes would be more efficient if they were targeted to need (i.e., aligned), were created after consultation with national and supranational bodies. These were then aligned with the priorities of Greek doctors, nurses, administrative personnel and social scientists to form an interdisciplinary response (Andrioti et al. 2015). Organisational needs to inform workforce development have proven highly beneficial (Ramklass 2009).

Conclusions and Implications for Practice

The evidence on whole workforce development in the world's health sector can be viewed as either presenting a fragmented approach with few consistent and uniform standards or a vibrant sector responding to unique local contexts with a mix of innovation and adaptability. The quest for standards continues through international organisations such as the WHO or national health organisations such as the National Health Service. The benefits of such an approach will include consistency of content, delivery and interpretation. Measures of success over a large population can also be derived and subsequently used to benchmark for either best practice or best fit. On the other hand, there is also an impetus for delivering short-term benefits in a sector undergoing rapid transformation and change. There are innovations in both approaches.

In terms of formal development, there is clear evidence that essential knowledge transfer to improve expertise through a formal approach is being complemented by practice-based learning, e-learning and social media learning. The modus operandi that was envisaged at the early stages of the advent of e-learning of combinations of learning interventions incorporating physical and web-based development has come to fruition in many areas. A mixed method approach to whole workforce development in the health sector is prevalent: on the one hand, traditional learning methods; on the other, new approaches, often web-based and widely accessible. The limitations of the latter identified in some of the studies discussed above should not necessarily be regarded as inhibitors. Checks and balances are being included to produce the most effective mix.

But it is in the area of accessibility that the greater innovations have taken place. The heading 'informal learning' was not meant to signify a process that was any less structured or valuable, but to indicate that not all learning is or need be classroom-based. International knowledge sharing, online lectures, information transfer and regional best practice are all valid learning vehicles. They have been embraced in many parts of the world. Whole workforce development has, by definition, a broad reach and the demands on healthcare outlined in Chaps. 1 and 2 are leading to increases in demand for a variety of reasons. It is essential therefore that

the 'supply side' consist not only of numbers but of quality, and whole workforce development can add to this.

Finally, the alignment of whole workforce development with the goals and objective of both organisations and individuals is important. Scarce resource in health has led to an imperative for cost benefit deliverables. The closer that the development activity is to goals of the various stakeholders, the greater the benefit. Demonstrating innovation in approach as well as alignment of programmes, however they are constituted, will reinforce the point of view and a virtuous circle will be created.

There are implications for practice from this narrative:

- The three principles of applicability, accessibility and alignment form a useful heuristic for whole workforce development.
- Alignment is critical. Ensuring that whole workforce development is designed to meet the needs of the organisation is paramount, and ensuring that it is applicable to the needs of the individuals in the workforce equally so.
- Having clarity about why the organisation is undertaking the development is an obvious point that is worth repeating. Training needs analysis matched against the organisations objectives will provide the answer to this question. Using other human resource outputs such as the strategic workforce plan will add further intelligence. Once this is understood, objectives for the specific training or development activity can take place in a structured context.
- The challenge then moves to the design of the development interventions, and technology and new social media have added to the choice in this area. No longer need whole workforce development be about a single intervention, but it can be adapted to both organisational and individual needs through the power of technology-based innovations, though evidence has shown that care needs to be taken when putting together the mixed media approach.
- The design of whole workforce development interventions will inform the delivery scale and scope of the delivery process. Once again, this is a judgement based on need, checks and balance. The design of a low-cost web-based development package may suit some but not all. Learning styles differ from person to person and from organisation to

organisation. It is essential that those responsible for delivering whole workforce development have an eye on this area. Best fit trumps best practice as in so many other areas of talent management in the health sector.

- Finally, there is an increasing need to build in measures of effectiveness for whole workforce development. For some areas, these will be straightforward and can be presented through patient or workforce data (satisfaction, labour turnover and so on); for other areas, less so. A move towards a balanced scorecard approach to measuring the effectiveness of learning, training and development is one possibility as a means of providing a strategic overview of performance and benefits.

The concept of whole workforce development is a critical part of talent management in health. It affects all members of a profession on the one hand or an organisational workforce on the other. It can also be a powerful tool to attract and retain employees and it is to this area that we can now focus.

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9

Attraction, Recruitment and Resourcing of Talent

A Paradigm Shift in Attraction and Recruitment in the Health Sector

The maxim that 'health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality' (World Health Organization (WHO) 2016: 6) resonates at an organisational level where recruiting those with the right skill mix is critical to operational efficiency, patient outcomes and an innovative health environment (Jończyk 2015; Oostveen et al. 2016). Attracting talented people therefore is important in two ways: firstly to satisfy immediate, operational needs and secondly to support the fulfilment of longer-term strategic objectives. But the 'ability to recruit the best talent with the skills to deliver high quality work … should not be underestimated' (Rodgers 2010: 340).

The recruitment process in the sector can be complicated by not only absolute health worker shortages (Shaffer et al. 2015) but also their relativity, leading to competition for talent and inherent tension between the global south and the global north, between countries within a region and within countries from organisation to organisation. The King's Fund

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summarised the position with three questions: how can employers support and develop a culturally and ethnically diverse workforce, how can employers retain international healthcare staff in the face of international competition, and how ethical is it for employers to continue to rely on health workers from developing countries when they themselves have shortages? (King's Fund 2004).

To date, relatively free labour markets have facilitated unprecedented movement of skilled health workers as they respond to demand and career opportunity, which mitigates (for some) rather than solves the problem of supply. Nevertheless, fifty-seven countries face severe shortages with pull factors such as targeted recruitment efforts and push factors, including low wages in source countries, contributing to the weakening of health systems for some and obstructing the achievement of national health goals for others (Taylor et al. 2011). It remains to be seen whether political change such as the UK's decision to leave the European Union or the potential tightening of border controls in the USA will affect labour mobility. In any case, recruitment will remain a strategic priority for the delivery of health services. For organisations, this means addressing the challenge in a way that is professional, ethical and responsive (addressed by the WHO Code of Practice of 2010 but with mixed results (Siyam et al. 2013; Edge and Hoffman 2013)).

To deal with these specific challenges, health sector organisations are focusing on their people management processes, amongst which attraction and recruitment feature highly (Heilmann 2011). But the scenario is markedly different from previous eras. Attitudinal change, additional generational perspectives and the use of social media as both a recruitment tool and a way of defining a particular health sector organisation through its brand and reputation are important factors in the way in which attraction and recruitment are approached. With respect to this latter point, the British National Health Service (NHS) Employers organisation noted that, in the UK, the whole healthcare sector was represented on multiple social media platforms, members of the public were discussing the NHS's performance from service to commissioning (NHS Employers 2014) and social media should be used to help advertise jobs. In the USA, 90% of hospitals had social media accounts in a 2014 study, up from 21% only three years earlier (Griffis et al. 2014), and examples

exist of the use of social media in health sector organisations in Asia and Africa. Attraction and recruitment to health are no longer the simple processes of job advertisement and response.

The Breadth of the Recruitment Challenge in Health

Recruitment and resourcing take place in a wide variety of circumstances but are characterised mostly by intense competition for talented health professionals. In New York State, for example, recruitment challenges were amongst the reasons why 33% of hospitals have had to reduce specialty services and 76% of hospitals had to take on temporary physicians to maintain adequate staffing (Terry and Brown 2016). Intense competition exists in the USA because public healthcare spending has been associated with employment growth for registered nurses, personal care attendants, physical therapists and assistants and occupational and recreational therapists; and 'Medicare spending, in particular, is linked to physician assistants employment; whereas, private healthcare spending is positively associated with primary care physician employment' (Pellegrini et al. 2014: 138). Around the world, a shortage of doctors in Gujarat (Purohit and Martineau 2016) and a shortfall of full-time nurses needed to meet demand in Japan and Taiwan (Yu et al. 2016) are further examples of recruitment challenges. In other parts of Asia, the problem of attraction and recruitment is prominent, although for different reasons by country. Singapore, Thailand and Malaysia recruit health workers from outside of the territory to meet local demand and for services to international patients. But this has resulted in the movement of specialised staff to private hospitals with the Philippines and Indonesia as the main exporters of doctors and nurses in the region (Kanchanachitra et al. 2011). In Europe, there are insufficient numbers to cope with complex healthcare (Batenburg 2015: 1537), making attraction and recruitment a priority. To compound matters, whilst half of the world's population lives in rural or hard-to-reach areas, most health workers live in cities (Capio and Bench 2015).

Competition for talent in health is ubiquitous. Nous, insight and professionalism of organisations will determine their attraction and recruitment success in such an environment. The nous and insight can be provided by combining external labour market intelligence with effective internal recruitment planning to provide the foundation for a systematic approach, incorporating a quantitative needs assessment (regional or local population-based to match demand and supply and anticipate recruitments needs) and qualitative analysis to meet the specific health requirements of the geographic area (Henchey and Rilly 2010). But it is the professionalism of converting identified need into the effective recruitment of health professionals in the right place at the right time with the right level of skills that will mark success. This will depend on the organisation having an attractive proposition (of which fair financial rewards are fundamental) to offer its potential candidates and efficient processes to ensure their smooth integration into the organisation.

A Context-Specific Approach to Recruitment

There is no 'magic bullet' intervention to address the attraction and recruitment challenges of all health sector organisations; the position is likely to be context-specific and addressed by a multi-factored response that would take account of 'health workers preferences for job characteristics and how their employment decisions are affected when presented with a combination of interventions' (Araujo and Maeda 2013: 2).

For some organisations, there has been a paradigm shift in thinking about recruitment caused by limitations in the traditional model of advertise-shortlist-interview-recruit, which, by itself, may not be robust enough to withstand the competitive intensity of contemporary labour markets and doubts about the effectiveness of some of the fragmented recruitment approaches adopted by health sector organisations in the past (Chartered Institute of Personnel and Development [CIPD] 2007). Processual limitations included too few responses to advertising to provide enough candidates to fill vacancies; or poor specification of the health role at the recruitment stage. Furthermore, change in the expectations of potential recruits in recent years means that more comprehensive

information beyond location, pay and grade is necessary as part of the attraction process. This is an important point because misconceptions or lack of information about the specific health sectors or professions can create problems (Nickson et al. 2008). Hence, acquiring talented people for health sector organisations is a two-way process of challenge and response where attraction and mutual assessment are important even before the recruitment process begins; and a more holistic value proposition is necessary to attract candidates, including factors such as monetary and financial reward but also career and professional development, the organisation's reputation and individual values and beliefs.

These factors mean having good human resources (HR) or people management systems and processes but also the ability to demonstrate talent management and its contribution to career opportunity and development, an important factor in the attractiveness of health organisations. In this respect, recruitment consists of four important groups of activity. The first is related to attraction, which means articulating the differentiated features of the particular organisation as a good place to work through a comprehensive employee value proposition (EVP); the second is projecting this to labour markets via an employer brand; the third is the recruitment process itself, including assessing potential candidates, and how this is aligned with good HR principles and those that have been identified as part of talent management; and the fourth is the onboarding, induction and orientation process which has a significant impact on whether talented people stay with or leave the organisation in the first year. Having a 'joined up' approach and ensuring that these are executed in an efficient way will be priorities of those involved in the talent management process.

Developing a Holistic Approach to Attraction and Recruitment

The convergence of multiple factors has forced changes in outlook on the part of not only the recruiter but also the recruit. Firstly, the increasingly global nature of health has had a concomitant impact on

those who work in the sector who may now perceive that they have a greater choice of employers; secondly, the significant transformation of the sector (new business or delivery models and new technologies) has created a need for different types of talent to implement new services; thirdly, there is a growing demand for talent to deliver existing services more efficiently (Connell and Walton-Roberts 2016); fourthly, privatisation and corporatisation (Srinivasan and Chandwani 2014) and an increasing investment in health have created in their wake a significant demand for key clinical, administrative and technical posts in almost every geography. These complexities are compounded by structural challenges such as the competition between public and private sector health organisations, macro economic policy such as ongoing pay restraint, between national and international opportunities that confront health professionals, and at an earlier stage between the very decision to move into health as a profession (Spines and Moore 2007).

The effect of these forces on the attraction of talent to health sector organisations has been significant. What was once considered to be 'recruitment' is becoming an extremely competitive, sophisticated, multidimensional process that involves factors such as the ethics of recruiting from other local providers within the region or from developing countries, the reputation of the organisation, the organisational culture in which the role takes place, and a broader framework for employment. Additionally, the ability to demonstrate the availability of learning, training and development, career opportunities and empathy with the career objectives of individuals, through effective and well-articulated talent strategies and management, will be important. Organisations increasingly find themselves needing a strong proposition against which potential recruits, at whatever level, can assess these prospects and a set of ethical guidelines which inform the recruitment process (Stordeur and D'Hoore 2007). In this respect, the concepts of healthy organisations or attractive institutions have been shown to be important in the recruitment process.

Ulrich's observation (2016) that talent decisions in recruiting, training and leadership in an organisation, as well as the use of indicators such as reputation of the organisation, would be critical in demonstrating effectiveness resonates across healthcare.

Building on Labour Market Insights

Against this backdrop, it is important to build knowledge and understanding of external factors such as labour market dynamics or relative positioning as an employer and internal ones such as the value proposition to employees or the nature of the recruitment process. In support of this, insights can be gained from studies such as that of Finnish doctors which concluded that a good workplace, career and professional development, and non–work-related issues were important factors in the decision to join an organisation (Heikkilä et al. 2014) or from evidence that nurses were attracted by the offer of task diversity and a competent, prestigious organisation (Van Hoye 2008) or from a wide-ranging study which found that the health employer image, job organisation and social dynamics and behaviour (Rutitis et al. 2014) were important decision factors. What this research shows is that there is support for a more human-centric approach to the question of attracting and recruit-

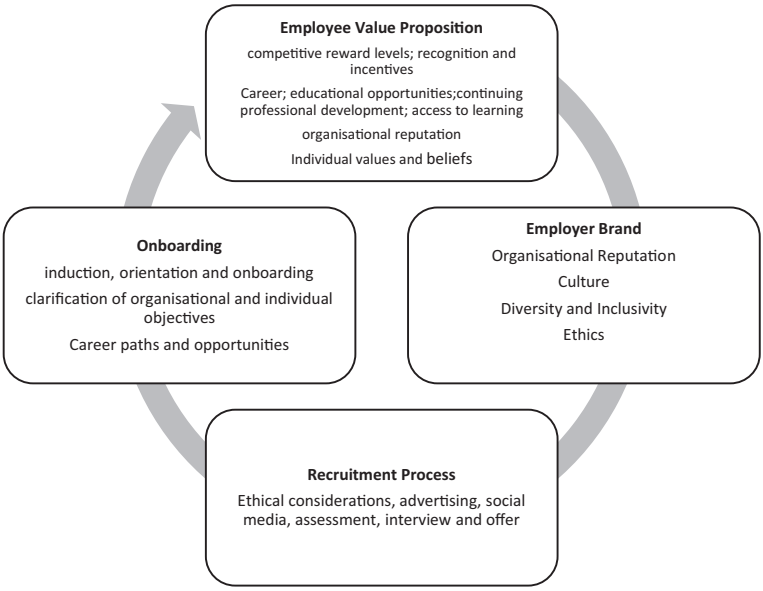

Fig. 9.1 The key components of attracting and recruiting talent into the health sector

ing talent to health to replace one that is purely process-driven (Nojedeh and Ardabili 2014). Talent management and its contribution to some of the factors that potential employees find attractive will play an important part in the process.

To address these complex challenges, health sector organisations have adopted, to varying degrees, the development of an EVP which is transmitted to the potential employees via the employer brand, more sophisticated tools of recruitment to ensure best fit, and an emphasis on the actual process of onboarding, induction and orientation to ensure that the promise of employment is matched by the actuality of employment in the early stages. These come together in the process shown in Fig. 9.1 and are discussed in more detail below.

Attracting Talent—The Employee Value Proposition

The intense competition in labour markets and the perception that attracting and recruiting talent have strategic, as well as operational, implications reinforce the need to have a proposition that will attract suitable candidates on the basis of a clear, credible and consistent understanding about what the potential healthcare employer has to offer and one that extends beyond financial considerations (Wilden et al. 2010; Williams et al. 2011), although it has been noted that in order to attract the best candidates, a competitive salary and benefits remain important (Hariharan 2014). At all levels a fair reward for the critical work done remains a fundamental part of the EVP. Other factors may not be as effective if this is not the case. The sum total of these benefits will be encapsulated in the idea of an 'attractive institution' characterised by a high level of job satisfaction and affective commitment, coupled with low intentions to leave (Upenieks 2005; Peltokoski et al. 2015). Added to this might be recognition and articulation of the philosophy of organisational excellence.

The practice that pulls together these various elements into a coherent whole is referred to as the EVP, which is a compelling offer that includes reward, monetary and financial benefits and a strong emphasis on non-tangible elements such as the organisation's reputation as a provider of

health services, its track record on corporate social and environmental responsibility, the level of inclusivity and diversity, and its approach to work-life balance and career development opportunities. The EVP describes what an organisation stands for, requires and offers as an employer. It provides a link between the organisation's values, people strategy and policy: how it delivers this through its workforce (CIPD 2016) and how these relate to the overall meaning embodied in the broader organisational or employer brand.

There is explicit and implicit evidence of the recognition of a more comprehensive offering in the form of an EVP in the health sector. A summary of the findings is included in Fig. 9.2. Araujo and Maeda's research for the World Bank, for example (2013), highlighted a variety of push and pull factors that had an influence on the employment decisions of health workers, including individual and personal factors such as gender, age and personal values and beliefs; work-related factors such as working conditions and the environment in which the employment would take place; and career incentives, including the opportunities for

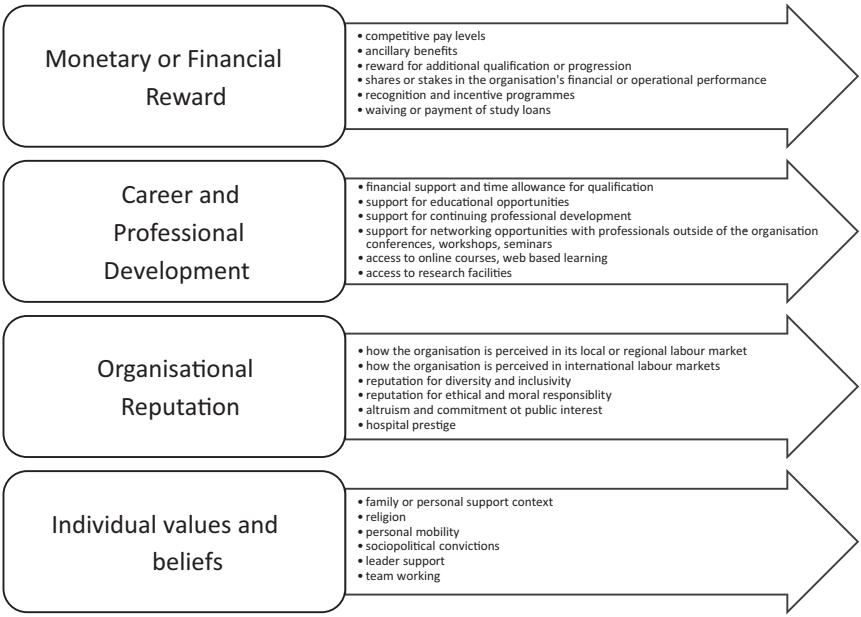

Fig. 9.2 An employee value proposition for health

continuing personal development. These were important factors in rural and remote areas of developing countries but would also be recognised by many in other geographies that were faced with similar challenges. These conclusions were supported by evidence from Norway, where multiple factors influenced recruitment and indeed increased income had less of an impact than non-financial factors (Holte et al. 2015).

A cross-geography study of the incentives used to attract physicians to health sector organisations in the USA, England and Germany also featured some of these characteristics and found that an EVP in this context consisted of both reward and professional development inducements. The findings led to the conclusion that a holistic approach to recruitment was necessary (i.e., a comprehensive EVP), including the importance of professional development and networking opportunities in addition to monetary or financial rewards (Janus and Brown 2014; Schmidt and Dmytyk 2014). In addition, the need to include opportunities for continuing professional development was seen as a 'pull factor' and part of the overall attraction or recruitment package to health sector workers (Lincoln et al. 2014). In Taiwan, the EVP for attracting inactive nurses to return to work included re-entry preparation programmes and flexible work schedules (Yu et al. 2016).

An excellent systematic review of strategies to recruit and retain primary care doctors found that a variety of interventions had been used to address some of the challenges outlined earlier (Verma et al. 2016). These included financial incentives such as waiving undergraduate fees in Japan, repayment of health profession student loans in the USA, and bonuses for extending tenure of service in New Zealand as well as non-monetary ones such as visa waivers to stay in the USA and organised scientific activity and continued medical education programmes in Norway.

The EVP as a means by which health sector organisations can articulate their attractiveness as a place to work continues to be developed. It is a holistic perspective that covers a range of factors across the employee life cycle, from reward to career development. It involves elements of communication, reward, access to research facilities or professional development, the working environment and available resources. It can be seen as a 'bundled package of multidimensional incentives' (Tran et al. 2012; Zheng et al. 2015: 239).

Having outlined the factors that are relevant and applicable to its own context, the organisation has the challenge of communicating this to its key internal stakeholders (as a retention tool) but, of particular relevance to this chapter, as a 'brand' around which an attraction or recruitment campaign can take place.

Attracting Talent—The Use of the Employer Brand

The employer brand comprises those attributes and qualities that lead to a distinctive image for the organisation and that suggest a particular type of employment experience. It consists of both tangible economic and psychological attributes (Barrow and Mosley 2005). The employer brand is the public representation of all of the benefits offered by a company that together create enthusiasm in job applicants and employees and add to their willingness to join or stay with the company. The employer brand is also a way of informing how an organisation approaches people management and it has the additional benefit of having a positive impact on organisational citizenship behaviour (Hurrell and Scholarios 2014; Fernandez-Lores et al. 2016; Gözükara and Hatipoğlu 2016). Considerable value was added to the concept in the health sector by the work of Rutitis et al. (2014), who developed and evaluated a conceptual model for corporate identity management in healthcare taking into account unique health sector characteristics.

The use of the employer brand began relatively recently (Kotler and Lee 2007) but has increased in a range of public sector organisations, including hospitals, universities, and government agencies, as they 'seek to express their identities through marketing and branding' (Whelan et al. 2010: 1164). It could be used to support both attraction and recruitment as well as improving employee loyalty and retention on the understanding that the brand paints an accurate picture of the purported qualities of the organisation (Moroko and Uncles 2008; CIPD 2016) and the actual employment experience, company culture and values.

Evidence for the importance of an employer brand in the employment decision-making process was reinforced by a study of why medical practitioners in Germany chose from public, non-profit, or for-profit hospitals. The findings showed the importance of employer characteristics such as altruism and a commitment to public interest as well as financial security, work-life balance, recognition and incentive programmes (Jackobson 2006; Winter and Thaler 2016). In the USA, the importance of creating a brand image for public health nursing was emphasised because the number of public health nurses had declined, thereby creating a need for greater recruitment efforts. A marketable image was developed with the objective of increasing visibility and this was successfully deployed throughout the USA and Canada (Baldwin and Lyons 2011). In Belgium, the prestige of the hospital was considered to be a critical factor in hospital-physician relationships as well as professional development opportunities, organisational support and leader support (Trybou et al. 2014). And in the British NHS, a Hospital Trust employer brand was created because 'recruitment advertising was bitty and fragmented, and there was no consistency between advertising and the material that applicants subsequently received. Bringing together all of this material and relating it to cultural and communication changes was key to improving both recruitment and retention' (CIPD 2007).

However, recognition of this value has not been universal. Research has shown that public sector managers can often overlook or misunderstand the reasons for using tools such as the employer brand (Whelan et al. 2010) with the possibility of a disconnect between the aspirations of the organisation through branding and those of its employees. A study of the attraction and recruitment of anaesthesiologists in Austria concluded that there wasn't enough evidence to support the use of company branding and image making alone in attracting candidates to healthcare organisations but that when combined with a more personalised targeting approach to potential applicants it could form the basis of an employer brand (Berlet 2015). These findings were supported by research in Finland (Heilmann 2011), where the need to develop the concept of marketing for health sector workers was recognised but more needed to be done to develop an employer image.

A conclusion is that, once again, the value of the employer brand would depend on the context of the health sector organisation. The advantages are that because of the competitive nature of the climate for recruiting talent 'one of the most important issues is how hospital organisations succeed in promoting their attractiveness' (Peltokoski et al. 2015: 955). A strong and meaningful employer brand will have benefit in this environment. But there has been a mixed experience of employer branding overall, and research has shown that 'current theoretical understanding on the nature, antecedents, and consequences of perceived external prestige is based largely on studies conducted in the western countries. Cultural and demographic factors may affect an individual's perception of external prestige as well as his or her response to it. For instance, individuals from high power distance cultures … may respond to external prestige differently than individuals from low power distance cultures' (Rathi and Lee 2015: 455).

The employer brand is a part of the attraction and recruitment process in health that is gaining in popularity but has yet to gain traction. However, the competitive nature of the health sector labour market suggests that such an approach may increase over the coming years.

The Recruitment Process—Applying the Employee Value Proposition and Employer Brand

The development of an EVP and employer brand is the precursor to the actual process of recruitment which in a contemporary sense would be multi-dimensional and multi-faceted. It would join up the various elements into a coherent whole from pre-employment to employment and onboarding, induction and orientation. The objective is to ensure a person-organisation fit between the candidate and the organisation 'where the value, beliefs and characteristics of the candidate are in line with the organizational environment and culture' (Syed Aktharsha and Sengottuvel 2016: 120). Evidence as to how this is achieved demonstrates the importance of context. As a result, there are variations in

the recruitment process between organisations and even within national bodies. In the British NHS, historically, 'universities and hospital trusts have been free to create their own recruitment processes as long as they were in line with employment law; this has led to variations between institutions in how successful applicants are selected: how the process is conducted, what aspects of the applicants are explored during the selection process and the breadth of individual values they are expected to showcase' (Miller and Bird 2014: 23). As a result, health sector organisations used a wide variety of selection and recruitment sources and tools (Newton et al. 2015) and in some cases customised recruitment strategies respecting the attitudes and expectations that might exist between gender, generations and culture (Spines and Moore 2007). A study of recruitment in the USA reflected the array of sources from which potential recruits could be drawn and identified a range of effective strategies, including increasing public awareness, word-of-mouth recruiting, cooperating with higher-education institutions and technical and community colleges, and online and website marketing (Slagle 2013). In the same region, this approach was reinforced by evidence from a study (Beck et al. 2012) which found that the tools of recruitment included websites and marketing through medical schools and professional organisations.

Organisations tend towards a mixed method approach to recruitment, includes the following:

- The implementation of targeted recruitment strategies for specific groups or geographies such as those in rural settings, where recruitment challenges are a recurring issue in many parts of the world (Kulig et al. 2015), to achieve gender equity (Alameddine et al. 2016), or neighbourhood recruitment to satisfy local needs (Shahidi et al. 2015).
- In Colombia, Costa Rica, Jamaica, Panama, Peru and Uruguay, the number of variations of how health sector workers were hired shows that a focused, targeted approach would be relevant. (In Jamaica and Peru, more than 30% of the health workforce is hired on temporary contracts.) Nevertheless, there is recognition in the region of the need for greater levels of attraction which include not only financial incentives but also accreditation and a broadening of educational opportu-

nities in health (Capio and Bench 2015). Complementing this, flexible recruitment practices included flexibility of rewards and incentives (Lincoln et al. 2014). In Canada, incentives as part of recruitment campaigns included student loan forgiveness, tuition forgiveness, education grants, signing bonuses and relocation expenses (Mathews and Ryan 2015).

- Online recruiting has grown in popularity. Research has shown that 70% of magnet hospitals (i.e., those hospitals in the USA that had demonstrated ability in the recruitment and retention of professional nurses during nursing shortages) advertised staff nurse vacancies on websites as opposed to 42% of non-magnet hospitals and that 89% of magnet hospitals had an online application process as opposed to 67% of non-magnet hospitals (Marrone and Razzak 2016). There are advantages of this process over traditional methods, including 'persuading candidates to apply and accept job offers is as important as choosing among candidates', the increased speed of the application process, the accessibility of information about the healthcare provider in which 'the use of the internet allows organizations to convey much more information in a dynamic and consistent fashion to candidates', the ability to return easily to websites hosting online recruitment, and the lower cost of online recruitment (Marrone and Razzak 2016).
- Furthermore, the use of social media as a means to connect with potential candidates is becoming the norm. A recent study in the USA found that 80% of those organisations surveyed used online job boards and 48% used social media sites (Maurer 2015). In the USA, the adoption of social media in healthcare organisations was seen as a strategic advantage not only in connecting with patients but also in recruiting and retaining millennial staff (Sarringhaus 2011). Social media is used mostly to advertise employment openings. A European study found that activity on social media had increased as a recruitment tool in several of the countries surveyed with varying degrees of application (Van de Belt et al. 2012); in the US study, around half of hospitals used social media in workforce recruitment (Hino 2014; Richter et al. 2014); and social media was used in nurse recruitment in South Africa (Lubbe et al. 2013)

- Word-of-mouth (virtual as well as physical) promotion as a way of advocating a particular organisation's (or professional group's) value proposition has met with mixed success. A recent study, for example, found that nurses in some regions weren't inclined to promote their profession and that the policy on the marketing of nursing as a career was inadequate. To counteract this, it was recommended that in this geography there be promotion of the image of nursing and of individual nurses during their daily activities and the implementation of programmes to promote nursing at the organisational level (Kagan et al. 2015). This would be a powerful message in, for example, Mauritius (Hollup 2012), where research showed that entering the nursing profession was regarded as the achievement of social mobility.
- Attention to processes to ensure that they are time-bound and transparent and have explicit rules for HR management and effectiveness in implementation will help to both improve governance and build trust. In addition, they should include clarity in job descriptions, role expectations and boundaries (Koskan et al. 2013; Kadam et al. 2016).

The EVP and employer brand, when combined with multiple approaches to communicating career opportunities, are powerful tools in the health sector recruitment process and are the basis for attracting potential candidates. The next steps concern assessing candidates and ensuring a smooth transition into the workplace once appointed.

The Recruitment Process—Assessment Tools and Techniques

The diversity of sources for recruitment into the health sector is matched by the diversity of the assessments and tools used in the process.

Amongst the various recruitment models are values-based recruiting (VBR), which as a method of healthcare workforce selection is one proponent of the recruitment process that is being established in the British

NHS. In this respect, VBR has been shown to improve teamwork and job satisfaction, reduce employee turnover and enhance patient care. The values associated with health sector work for which potential candidates might be assessed, include care, compassion, competence, communication, courage and commitment (Miller and Bird 2014). Values in the British NHS Constitution against which talent is recruited are everyone counts, working together for patients, compassion, improving lives, respect and dignity, and commitment to quality of care (Power and Clews 2015).

VBR also features at the US Mercy Group, where there is a great deal of emphasis on cultural fit, which is reflected in recruitment processes in three areas: (1) criteria fit, which assesses knowledge, skills, experience and education; (2) 'mercy fit', by which those with personal values are aligned with those of the organisation; (3) talent fit, which assesses 'a person's natural ability to achieve near-perfect performance without effort … talent represents a consistent pattern of thoughts, feelings and behaviors' (Thompson and Ahrens 2015: 49). The talent fit interviews are based on assessments to provide predictive validity whilst highlighting specific talents. The values approach facilitates the process of 'recruiting staff that do their work with love and are committed to the organization' which improves hospital performance (Nojedeh 2015).

Where challenges are faced in recruiting (such as those faced by public sector organisations when matched against those of the private sector), positive perceptions of the recruitment process, the potential for deployment to a range of roles and enhanced career progression will play an important part in the attraction process (Kadam et al. 2016). The ability to attract talent to the organisation as the first part of the 'talent cycle' (Tansley et al. 2007) has now been reshaped against this new framework. But the recruitment process should be efficient because it has been shown that a slow, sporadic recruitment system could have a deleterious effect on the achievement of recruitment targets (Purohit and Martineau 2016). Figure 9.3 shows how these various elements of the recruitment process may be linked together.

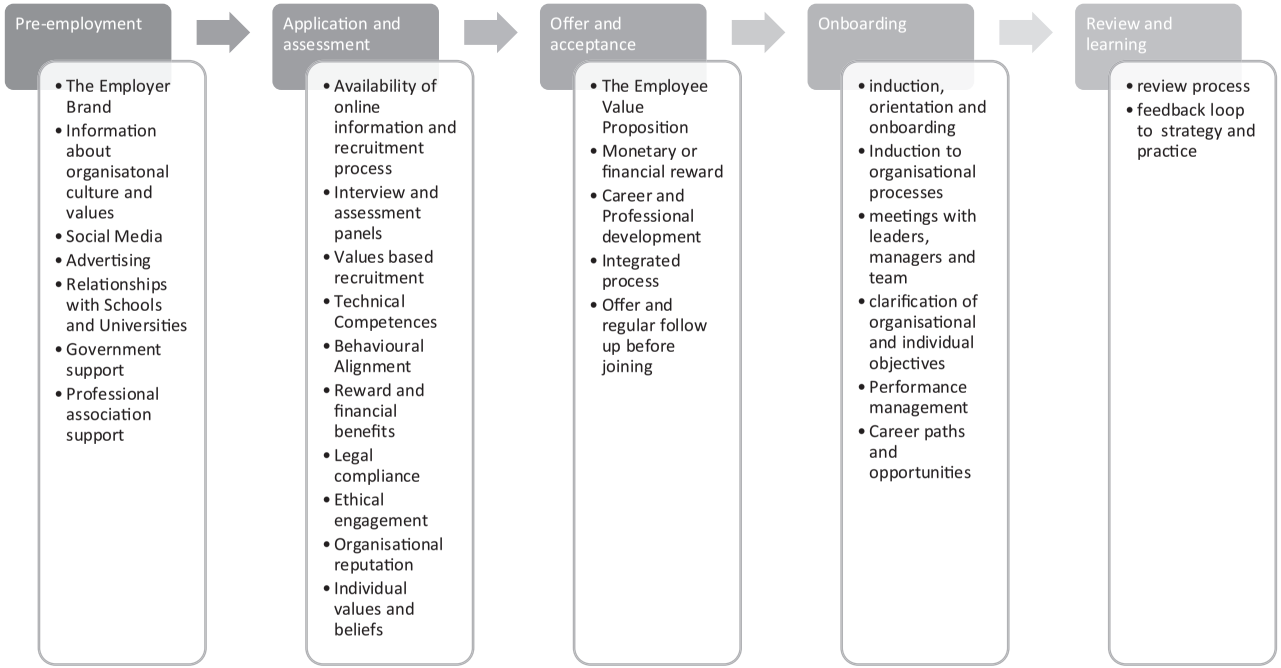

Fig. 9.3 The recruitment process linking the employee value proposition, employer brand, assessment and onboarding

Onboarding, Induction and Orientation

An onboarding, induction and orientation process which 'emphasises the educational steps needed for the purposes of professional learning and development' is highly desirable and valued by nurses and physicians (Peltokoski et al. 2015: 955). On the flip side of this, 'the result of poorly trained or misinformed staff costs the organization by affecting the brand, reputation, and customer satisfaction. The difference between long and short term retention of an employee often pivots on an effective orientation' (Baldwin 2016: 26). Both are relevant across most health sector employee groups and reinforce the premise that the more an organisation can make new employees feel welcome and prepared for their new jobs, the quicker they will be able to contribute to the success of the organisation, the more engaged they'll be and the better the chance that they'll stay with the organisation over time.

Onboarding can be described as encompassing the early stages of an employee's time in the organisation and is a term that includes induction and orientation. It's possible to identify three aspects of the process. First, there is the initial induction which begins with the offer of a job and includes the new employee's arrival at the place of work. This is followed by orientation, which is about meeting colleagues and managers as well as learning about the organisation's structure, values and expectations. Finally, onboarding is the 'whole process over a longer period starting with the individual's contact before they join through to understanding the business' ways of working and getting up to speed in their job' (Turner 2014). Onboarding normally takes place over a predetermined period (up to 6 months) and includes elements of the organisation's culture, values and objectives.

There are issues arising during this phase that are common across healthcare disciplines, and 'the comprehensive orientation process offers contributions to newly hired nurses' and physicians' transition into the practice environment' (Peltokoski et al. 2015: 955). There is evidence of the extensive use of onboarding in US hospitals and health systems where experience had shown that new employee orientation had a significant impact on both employee engagement and retention and that

the success of this had made it a priority for some organisations. In New York, hospital systematic onboarding programmes were used to help staff become familiar with business processes and technology and were aimed at minimising the time it took for employees to attain full productivity as well as making them aware of and satisfied with job responsibilities (Weinstein 2013).

The success criteria for onboarding in the health sector include clarity of the benefits of orientation and responsibilities for who should deliver it. In this respect, if 'the orientation process is valued throughout the hospital and responsibilities for orientation are shared between the newcomer, team members and preceptors, as well as managers and hospital administrators', these will add to both the success of the individual and the attractiveness and employer brand of the organisation (Peltokoski et al. 2015).

Case Study: Developing Talent in Clinical Leadership

Dr Niki Kyriakidou, Leeds Business School; Mr Kostas Papagiannopoulos, President-Elect, European Society of Thoracic Surgeons; Mr Alessandro Brunelli, Secretary-General, European Society of Thoracic Surgeons

The rise in healthcare leadership is a global trend. It has been established for over thirty years and now attracts reforming health policymakers, thus resulting in cultural changes in the health sector (Enock and Markwell 2010; Veronesi et al. 2013). It is a complex business attempting to manage hospitals effectively, and the major challenge is how to deliver high-quality healthcare through appropriate planning in the presence of limited resources (Dalmas 2012).

Most recruiters, in their quest to identify talented managers to lead, focus traditionally on competencies, knowledge, skills and qualifications as these are generally easier to articulate, identify and measure. Several qualitative studies have pointed out that major factors related to the improvement of overall hospital performance are physician engagement, leadership, culture, strategy, structure, good communication, training, skills and information (Brand et al. 2012). However, values, personality traits, organisational behaviours and motivational drivers are of equal value to identify talents. While the competencies, scientific expertise and professional experience provide valuable data and insight about an individual's credibility for a particular function, position and role responsibili-

ties, personality traits and personal drivers help to assess a person's potential for developing leadership qualities, hence promotional opportunities into management.

Cases of Clinical Leadership

The following cases show the impact that doctors may have in their medical practice when they exercise their qualities as managers of hospitals. In both examples (Italian and Belgium cases), the consultants can play prominent roles in promoting change within their health organisations. Reflecting on the Belgium case, a clinical leader may become a potent force and hold wide appeal to reforming policymakers. His innovative practices resulted in a great cultural shift of main stakeholders involved in managing health conditions, developing services and helping to shape learning and development as clinicians, managers and commissioners. As such, the consultant of the case study can exercise leadership qualities, manage talent within the hospital and make informed decisions since he has expert knowledge within the core of the health organisation where he is operating.

Reflecting on that, Clay-Williams et al. (2014) argue that some of the advantages of having doctors in management are their strengths in dealing with the structure and process of the organisation, the outcomes of patients, issues of safety and quality, and their ability to make informed and intelligent decisions about patients and organisational processes. This fact is supported by the clinical leader working at the Italian health organisation, who demonstrates good leadership qualities such as strong values, ethos, and integrity with colleagues and patients which leads to an increase in his credibility and causes him to be seen as a role model by other medical staff, thereby attracting other talented clinicians.

The Belgian Case: Applying Talent Management to Clinical Leaders—Mr Kostas Papagiannopoulos

Talented leaders/managers are a sine qua non of every healthcare system.

Several years ago, I had the opportunity to witness the Belgian healthcare system, where I was employed as a junior consultant. Soon after commencement of employment, I realised that the department had all the skills and expertise required to provide excellent care to patients but was not able to identify well-established, standardised and recorded standard operating procedures (SOPs) for the postoperative management of patients, a common language amongst nursing, junior medical and senior medical staff members.

Obstacles to overcome:

- Persuade team members of the need for such SOPs in an established practice
- Engage senior team members with established ideas and habits

- Engage all three core teams of the department (nursing staff, junior doctors, and senior medical staff)

The need was obvious but the message was challenging. Being a new member and not the most senior, I spent a period of time preparing an appropriate business case tailored to the needs of the individual system on the basis of evidence (preparation and tailor-made presentation).

I therefore identified and approached individual talents within all three teams who were respected amongst peers and were influential but also had the skills and the vision to identify innovation (identify talents).

I offered a period of consultation, allowing the case to become embedded, listening to and not just hearing comments and suggestions (teamwork, sense of ownership, and opportunity to be heard).

The most critical step was assignment of segments of the business case to individuals from all different teams with short cycles of auditing and insisting on deadlines (teamwork, healthy competition amongst team members, global engagement and ownership, team building, delegate responsibilities while coaching and keeping control, and identify and employ different styles of leadership).

At the conclusion of the business case and the successful implementation of SOPs, an official presentation was arranged in hospital. It allowed other teams to witness a good piece of work, offered well-perceived recognition to all who worked hard for the completion, teased out the talents within the team and awarded the enthusiasts and innovators of the team. The end result was rewarding as the business case was completed in time, was accepted by all team members as it had several individual flavours, and left a sense of satisfaction and pride to all those who had worked with passion and enthusiasm (sense of ownership, address and reward the talents, share good ideas and market them to a wider audience, and keep talents engaged).

The Italian Case: Developing Leadership, Not Just Leaders—Mr Alessandro Brunelli

An example of participative clinical leadership was the start a single-port minimally invasive thoracic surgery programme in the Department of Thoracic Surgery in Ancona, Italy, in which I have been working for more than 20 years. In the early 2000s, the advent of minimally invasive thoracic surgery, keyhole surgery, revolutionised our specialty. Our centre was experiencing a difficult period of reduced productivity.

There was a need for an effective change that could boost the image of the unit and attract referrals.

In that period, I had the chance to observe this new technique from a famous surgeon. I immediately perceived this technique as a valuable change to introduce in our unit, a change that could (1) revitalise the

morale and enthusiasm of the team and (2) increase surgical referrals and productivity.

The most important leadership skill to successfully implement this technique in our unit was my ability to set direction and communicate this to my colleagues. In that situation, it was critical to convince the team about the strategic importance of implementing the new technique. Communication was the key to the success of the programme. In fact, the first step was to communicate my vision to the other team members and buy them in. I presented and discussed my vision and objectives with my colleagues in the context of the emerging needs of the unit. Using a participative leadership style, I encouraged my colleagues to share their ideas and opinions, engaging them in the process. This was important as they all felt part of the project even if they initially were not directly involved in the surgery. The stepwise approach was well defined from the start in order to avoid misunderstanding and win resistance. Taking into consideration the opinions of my team members, I was able to set direction by building a guiding team consisting of two surgeons, who started to learn and apply this technique and subsequently were able to tutor the rest of the team. This led to increased surgical activity and productivity of the unit again.

Conclusion

As complexity in healthcare increases, European health management systems require leaders (at every level) who can identify needs and current challenges in their practice, shift and adapt quickly, be resourceful and effective, thrive on organisational change, inspire others and make sense out of uncertainty and resistance to change for those they lead.

While the competencies and professional expertise/experience provide valuable information and insight about an individual's credibility for a particular role/position/responsibility, personality traits and personal drivers help to evaluate a person's potential for developing leadership qualities, hence promotional opportunities into leadership positions.

Conclusion and Implications for Practice

There is a paradigm shift in the attraction and recruitment of talented people into the health sector. Traditionally, the process has been one of responding to vacancies through a straightforward process beginning with the advertisement for the role and ending with a job offer. This approach is tried and tested and is still relevant but may not be sufficient to deal with the talent shortages in health. So the conclusion from research into the challenges in recruiting in rural areas in the USA that 'recruitment

and retention success can be best achieved by adopting a multifaceted approach' (Stretton and Bolon 2009: 10) is appropriate:

- In the first place, there is more emphasis, pre-employment, on strengthening the external articulation of the organisation's employment reputation and strengths as well as the role itself. This means developing an employer brand that represents the actuality of working in the organisation and what it stands for. The employer brand is a public articulation of the attributes and qualities of the organisation leading to a distinctive image and a particular type of employment experience. Being recognised as one of the best companies to work for can be a powerful message to potential recruits. (In the USA, healthcare service providers regularly comprise 10% of the 100 organisations recognised as the country's best workplaces; the UK NHS lists over 100 healthcare workplaces.)
- Secondly, have an EVP that includes a range of monetary or fiscal benefits but also a strong message about career opportunities, the place of work, the people in the organisation and its values. Texas Health Resources, one of the leading USA 'best places to work in healthcare' in 2015, embodied a culture where people lived the values and where the visibility and transparency of senior leadership were evident; Baptist Health South Florida was recognised for its employee development programmes; and St Jude Children's research hospital offered reimbursement for staff tuition (Lorenzetti 2016). In the UK NHS, in 2015, Acute Trusts, Acute Specialist Trusts, Community Trusts, Mental health Trusts and Clinical Commissioning Groups were recognised as 'best places to work' (NHS Employers 2015), whilst healthcare organisations in Ireland, India, Canada and Spain all feature in surveys of the best places to work (Great Place to Work 2015). This deserved public recognition is not just about winning awards. It is also about enhancing the ability of the organisation to attract talented health professionals.
- The third important conclusion is about the actual recruitment process. Health sector organisations have recognised the need for a professional approach that combines quality and speed. The use of web-based recruiting is increasing in the sector because it enhances both. In addi-

tion, the necessity for those recruiting employees to include a combination of technical competence and behavioural suitability is recognised, and the recruitment process will take account of both.
- Finally, the need for effective onboarding, which can take place over an extended period of up to 6 months, is also an aspect of attraction and recruitment into health that has been recognised as a platform that reinforces the position of the organisation in the labour market.

The use of sophisticated attraction and recruitment methods in health in a very competitive market for talent can be positive. However, there is also evidence that the use of any individual element of those outlined above per se may not produce the required results. Instead, an integrated process in which the employer brand is the articulation of a strong EVP which itself is underpinned by resilient, multi-channel recruitment and a comprehensive onboarding process is more likely to produce the desired outcomes for the recruiting organisations.

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10

Talent Management and Employee Engagement

The Meaning and Importance of Employee Engagement

Engaged employees in health sector organisations have a positive impact on quality of care and patient satisfaction and safety (Hilton and Sherman 2015: 52; Kim et al. 2016). They contribute to improvements in clinical processes as well as health and financial outcomes (Bargagliotti 2012; Studer et al. 2014; Molefe and Sehularo 2015; Decker et al. 2016). It is for these reasons that the ability to engage is seen as a vital factor in building sustainable healthcare organisations (Mihail and Kloutsiniotis 2016; Strömgren et al. 2016: 117), where sustainability results from a combination of engagement, enablement and energy (Willis Towers Watson 2016).

Employee engagement is a term used to represent the positive, proactive behaviour in the workplace that emanates from a combination of motivated, emotionally attached employees and integrated, enlightened people management activities and empathetic managers working towards the achievement of clearly communicated objectives.

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It is a work-related state of mind of positivity, vigour, dedication and absorption (Schaufeli et al. 2002; Bjarnadottir 2011). It encompasses cognitive, emotional and physical elements and is underpinned by meaningfulness and psychological willingness or availability (Bedarkar and Pandita 2014; Thompson and Ahrens 2015). Employee engagement is the relationship, beyond job satisfaction or motivation, an individual has with work, to decisions regarding employment, commitment to the organisation, and behaviour and interactions in the workplace. It means being psychologically present when performing an organisational role (Saks 2006; Collini et al. 2015: 170; Macauley 2015: 298). Engagement is also important because it can be a mediator of relationships with and between a variety of people management and development practices (Shantz et al. 2016).

In this respect, ground-breaking work by Katz and Kahn (1966) and further scholarship by Kahn (1992) provided a foundation for the understanding of the benefits of employee engagement; and the work of, inter alia, Shaufeli and Bakker (2004), Bakker and Demerouti (2008) and Markos and Sridevi (2010) showed how it could impact on individual and organisational performance. The outcomes of sustained levels of employee engagement were identified as higher quality, more commitment to the organisation, and more willingness on the part of employees to go the extra mile for the organisation (Thompson and Ahrens 2015), with lower attrition rates as an additional benefit. Those organisations that are able to provide a workplace culture with meaningfulness (job enrichment, work-role fit), safety (supportive manager and co-workers) and availability of resources have a better chance of producing engaged employees (Jauhari et al. 2013: 162).

Where organisations can find the *locus of engagement*, they could go some way to explain the variations between individuals and the points at which employees connect in the workplace (Chartered Institute of Personnel and Development [CIPD] 2011). Talent management can help to facilitate these points of contact. Understanding how the two work together will be important for health sector organisations.

The Challenges of Engaging a Diverse Health Workforce

But the scale of the challenge was evidenced by a recent study of healthcare engagement in the USA which found that, although 44% of those surveyed were engaged with their organisations, 15% were detached and 18% disengaged (Willis Towers Watson 2016). The diversity of the scope and structure of health service organisations makes the task of engagement a difficult one.

In the first place, the number of roles, structures, business/service models, stages of development of people management practices, and level of expectations from a variety of stakeholders, including government, shareholders and patients, indicate a complex environment. This was reflected in the findings of a meta-analysis of employee engagement in the nursing profession which showed 77 influencing factors in six themes: organisational climate, job resources, professional resources, personal resources, job demands, and demographic variables; and 17 outcomes in three themes: performance and care outcomes, professional outcomes, and personal outcomes (Keyko et al. 2016). How to navigate these complexities and develop policy around the influencing factors to facilitate employee engagement is critical. Amongst the ways of so doing are an adaptive style on the part of the organisation's leaders and managers; 'the ability to lead effectively is based on a number of skills, including communication, motivation, vision, modeling, demonstrating empathy, confidence, persistence, and integrity' (Jones 2015: 19); and a range of talent interventions. Integrating those 'talent' factors that contribute to engagement, such as career paths, development opportunities and consistency in organisational behaviour towards talented people (Wall 2015), will provide the foundation on which the constructs of employee engagement can coalesce with those of talent management.

It might be argued that employee engagement in the health sector will be best addressed in a pluralistic way with emphasis on engagement among both those employees who rank highest in terms of performance and potential and engagement processes that apply to and release the potential of all employees. In hospitals, employee engagement is a concept

that concerns the whole organisation from point of care (Simpson 2009) to non-clinical, technical and ancillary employees. Clarifying boundaries and differentiating it from other concepts within the people management and development area will provide the basis for coherent talent management actions.

At the highest level, this will consist of mission and purpose which will be stewarded at the board level. However, since engagement is an individual-level construct (Saks 2006), it will also be important to ensure that there is synchronicity between the aims and objectives of individual employees and those of the unit, department or organisation as a whole. Throughout the organisation, issues such as meaningful and motivating work (Serrano and Reichard 2011), the environment within which it takes place, and the availability of career development will be critical success factors. Understanding the findings for each of these will facilitate the identification of their talent management implications, although it should be borne in mind that each organisation will have unique triggers for employee engagement leading to different experiences; that is, what worked in one might not work in another (Baron 2012).

The Influencers of Employee Engagement

Four critical factors are important influencers of employee engagement in regard to the relationship with talent management, as shown in Fig. 10.1. These are mission fulfilment (including shared purpose or values), meaning at work, the working environment (including interpersonal relationships) and career development opportunity. These are of course underpinned by the perception of fair reward; a critical factor in engagement.

The first of these—mission fulfilment and shared purpose and values—is important because this was amongst the factors that increased engagement and reduced turnover rates in health sector organisations in the USA, the UK and elsewhere (West and Dawson 2012; Collini et al. 2015; Zhu et al. 2015; Anand and Fan 2016). In this respect, mission fulfilment is defined as 'the state in which an organisation consistently acts (publicly and privately) in a manner that is congruent with and leads

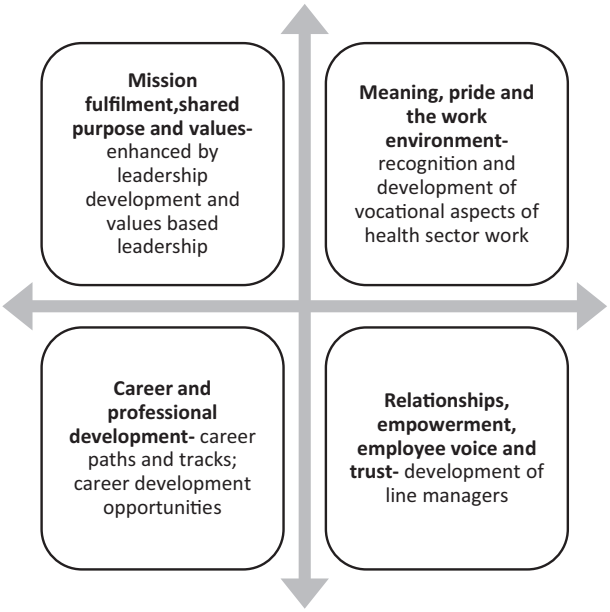

Fig. 10.1 Drivers of employee engagement in the health sector

to the fulfilment of its corporate mission statement' (Collini et al. 2015: 172). Understanding the practice implications of the mission will allow those at the point of care to achieve more control and autonomy (French-Bravo and Crow 2015).

There is value when the health employee bridges 'the gap between the aspirations contained in the mission statement and the experiences of their patients' (Bart 2014: 44). In health, there is a strong vocational element to engagement which enabled individuals to go beyond regarding the role as a job and more as a calling, and where there was a sense of 'meaning' at work this also had powerful engagement outcomes. In a study of South African health workers, 19% of variance in organisational commitment and 30% variance in work engagement were due in some part to these factors. The impact of this was that nurses who felt they had a meaningful contribution to make were more inclined to stay in the organisation (Beukes and Botha 2013), a point also reinforced for care givers in Denmark (Nielsen and Jorgensen 2016).

Secondly, enhancing the meaningfulness of work will enable health sector leaders to create an environment of positivity from which improved performance outcomes will stem (Cziraki and Laschinger 2015; D'innocenzo et al. 2016). Those who find meaning at work 'are more competent, committed and contributing; in turn competence, commitment and sense of contribution lead to increased customer commitment; in turn customer commitment leads to better financial results for the company' (Ulrich and Ulrich 2011: 3). Evidence points to the importance of meaningfulness as a critical factor in employee engagement and indeed 'this was almost seen as a fundamental driving force among the nurses, and it seemed as if this driving force contributed to the creation of resilience in particularly challenging situations at work' (Bjarnadottir 2011: 32). But 'organisations are only as gifted at generalising ideas as the individuals who compose them' (Ulrich and Ulrich 2011: 199).

Within the boundary of meaningfulness, the importance of a good working work environment for patient–health specialist interaction and the impact this can have on engagement has been identified (Ansmann et al. 2016; Goh and Lopez 2016). When employees are happy and loyal, they will be more engaged and positive about their workplace and team (Macauley 2015: 299). In this respect, the culture of the organisation and the impact this has on employee engagement are important since these can influence the quality of care provided (Rovithis et al. 2016). Furthermore, as shown in a study of French hospitals, the support given at the place of work to ensure a positive work environment can have a significant impact on nurses' and nurse aides' affective commitment (Ruiller and Van Der Heijden 2016).

Thirdly, there is complementarity between the working environment, the types of employee relationships that take place in that environment (including employee voice), trust and both individual and organisational performance. Interpersonal relationships are important to employee engagement in all situations, and professional and social support from colleagues and managers was 'the most important resource for positive adjustment to challenges at work' (Bjarnadottir 2011: 32; Othman and Nasurdin 2013). For example, there is a positive and significant relationship

between employee empowerment and quality of output in the health sector (Hashemy et al. 2016), whilst 'improved trust, cooperation, communication between professional groups and improvement of the work environment in operating rooms' (Strömgren et al. 2016: 118) had an impact on patient safety.

Perceptions of trust between employees, between employees and managers and between employees and the organisation are considered essential for long-term stability and well-being (Purba et al. 2016: 174). The theoretical foundations for trust and its role in employee engagement can be explained by social exchange and social capital theory, which state that relationships of trust develop over time (Macauley 2015: 298), and where trust was strong it could be a powerful factor in attracting and recruiting as well as engaging talented people (Johnson and Beehr 2014). The strongest predictors of overall satisfaction and engagement included department governance but also collegiality, collaboration and the relationship with supervisors (French-Bravo and Crow 2015; Wai et al. 2014).

In this category of influencers, employee voice is the means by which the workforce communicates its views, in a discretionary way, on a range of issues relating to employment or organisational performance to managers, executives or the board in a way that would influence those things that affect them (Adelman 2012; CIPD 2016; Kwon et al. 2016) and can refer to organisational democracy, industrial citizenship, free speech and human dignity (Mowbray et al. 2015). It is relevant to the health sector since 'the voice, rights and responsibilities of health workers must play a central role in developing and implementing solid policies and strategies towards universal health coverage' (World Health Organization [WHO] 2013: 22). Respectful communication in health sector organisations has a positive effect on employee engagement and behaviour and the concomitant impact on organisational effectiveness (Adelman 2012; Cohen et al. 2015). It is also argued that the conceptualisation of employee voice should not be static but should evolve to take account of either sociocultural or technological change such as that epitomised by social media (CIPD 2013).

The fourth area of influence on employee engagement concerns the importance of career and professional development (Trinchero et al. 2013; Didem and Zümrüt 2014; Holdaway et al. 2015; Al Mehrzi and Singh 2016). There are numerous examples of the strength of this factor. Research on the work experiences of registered nurses in Italy as part of a wider study to identify the antecedents of employee engagement in health, for example, concluded that investment in continual professional development was a critical factor in enhancing nurse engagement in both private and public healthcare settings. The study concluded that 'nurses provide a vital service to the public and continual training is an important component of ensuring they have the competence to deliver best-quality care to the patient' (Trinchero et al. 2013: 813). This also had a beneficial effect on employee engagement. Furthermore, studies of engagement in the USA around the creation of new career ladders (Colwell 2016) and in China and Korea (Zhang et al. 2015; Kim et al. 2016) found that professional development and job rotation, one aspect of career development, were positively related to engagement, a dynamic that was reciprocal since a higher level of engagement also led to greater career commitment. Leyenaar et al.'s (2014) research amongst paediatric professionals in the USA found that tertiary care hospital employees prioritised career development as a key aspect of satisfaction and, by implication, engagement.

In summary, employee engagement is a critical aspect of the health sector organisation's culture, the level of which can influence a wide range of variables from performance to the employee's willingness to stay with the organisation. Furthermore, the differences in the characteristics of employee engagement, whether they be geographic or organisational, will have to be identified if effective actions are to be taken; thirdly, there are multiple influencing factors, some with universal applicability and some that are organisation-specific. Drawing linkages between such factors and talent management will therefore be a factor of generic theory and conceptual understanding (i.e., what should drive employee engagement and what actually drives employee engagement) and the dynamics of individual organisations.

Aligning Talent Management and Employee Engagement

Health sector employees who are engaged and committed can achieve higher productivity and are less likely to leave. But to arrive at this position requires a combination of factors, including a mix of strategic (mission and vision) and operational (values and behaviours) factors. Vital to this are leaders with the competences to deliver and leadership actions that do so (Forni 2009; Shacklock et al. 2012), backed up by managers who regard engagement as a key part of their role and a fully developed workforce.

The probability of successful outcomes for both the individual and the organisation will increase where talent management, human resource (HR) development and HR management (HRM) are complementary. Hence, talent management activities should be part of a broader HR approach to the specific challenges of employee engagement. This assumption is reinforced because a homogenous solution to employee engagement issues is unlikely. Instead, tailored proposals will be required because of the varying strengths of mediation of employee engagement influencers between healthcare groups (Shantz et al. 2016). Nevertheless, talent management will have a distinctive role to play in engaging the health sector workforce. In this regard, the definition of talent management is likely to be pluralistic (i.e., pertaining to a broad swathe of the workforce and relating to the needs of both individuals and the organisation). Conventional views about responsibility and accountability for engagement give ownership of the process to, in the first instance, those at the board level, who will try to ensure that senior managers make engagement a priority (Lightle et al. 2015), and, secondly, at the executive level, where 'high visibility leadership' will convey both the mission and meaning, beginning with the induction or onboarding process (Forni 2009) and continuing throughout the employee life cycle. These two groups would be covered by talent management activity around leadership competences and development. However, pluralism in approach means that two further areas of talent management will be considered. These are the role of line managers and whole workforce development.

Case Study: Talent Management Challenges in the Indian Health Sector

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India is passing through a transition period. On the one hand, democracy, political certainty and careful economic reforms are reaping benefits by improving the economic growth outputs of the nation and encompassing a larger socio-demographic segment of the country to experience the success of globalisation. On the other hand, this growth has created an inequity between social classes on the basis of their proximity to access and utilise infrastructural setup like health, education, transport and housing needed to participate in wealth-creating opportunities. Providing quality healthcare to people is perhaps the biggest challenge of all for the government to achieve its aim of being an "economic superpower".

India has always lagged behind its peer group in terms of investment to create health infrastructure and workforce. For instance, a recent study finds that India spends 1.08% of its gross domestic product on healthcare, has slightly more than 20,000 hospitals for 1.3 billion population, and has 1 doctor for every 11,000 people (Central Bureau of Health Intelligence [CBHI] 2015). Over the last few years, the government has promoted investments through public, private and public-private partnerships to build new healthcare facilities and train additional workforce (Dang et al. 2016). However, this investment flow has created a further divide between rich and poor and between urban and rural areas, creating a barrier towards making affordable healthcare a "universal access". Recent health statistics show that the average number of beds in urban hospitals is 140 as opposed to 10 beds in rural healthcare centres (CBHI 2015). As a result, India ranks among the top 20 countries in the world in its private healthcare funding (Chatterjee and Srinivasan 2013) with examples of tertiary healthcare assets based in urban cities that are comparable to global best in class on the one hand but some areas of primary healthcare, particularly in rural areas, do not measure well with international comparison (Nair 2017).

Hence, various stakeholders, including the government, private sector, health insurance industry, pharmaceutical sector, and medical device and equipment industry, have to work together to improve healthcare access (McKinsey 2012). This complicated environment where stakeholders often have conflicting objectives has serious implications for four areas within talent management.

The first of these is to ensure that there are sufficient, qualified and competent talented health professionals to meet the demand for health service. This is of particular importance because India has a shortage of qualified health workers and the workforce is concentrated in urban areas (Rao et al. 2011). The response has been both at the sectoral level, including

government policy to increase educational curricula and an initiative to make medical education available to a broad range of candidates through information technology (Saxena et al. 2015), and at the organisational level through innovative approaches to the recruitment, development and retention of health workers (Srinivasan and Chandwani 2014).

The second is the challenge of retaining talented people once in post. Both the World Health Organization and the World Bank have highlighted the need for education policies, monetary incentives, non-monetary incentives, skills substitution, and regulatory policies as possible solutions, concluding that to be effective 'interventions need to be implemented in bundles, combining different packages of interventions according to the country's socio-economic context and characteristics of the health workers' (Araujo and Maeda 2013: vii). There has been recognition of the need to integrate talent management with other HR initiatives such as performance management, training and development, and workforce planning (Srimannarayana 2015). It is envisaged that this approach will be a contributor to the ability of Indian health organisations to retain key talent.

The third area of interest is managing the expectations of a diverse, multi-generational workforce, which is proving to be one of the most challenging of contextual factors. This emanates from the numerous ethnic, religious, linguistic, caste and regional collectivities in which 'India has often been described as a panorama, which has absorbed diverse languages, cultures, religions and people of different social origins at different points of time in the past. Not surprisingly, these diversities are reflected in patterns of life, styles of living, land-tenure systems, occupational pursuits, inheritance and succession rules, and management system(s). Due to its complex socio-cultural configuration, the Indian business context is unique, and is often referred to as a "cultural island," different from every other nation' (Budhwar and Varma 2011: 319). Such diversity requires an inclusive and responsive approach to talent management.

The fourth is ensuring the right level of leadership talent to manage health transformation which has been identified as critical to health sector organisations because of globalisation, rapid changes in technology, and the increasing demand for accountability in performance (Kumar et al. 2014). The challenge facing those responsible for talent is to 'develop homegrown leaders who can understand the Indian business environment, and yet operate with a global mindset … how to lead a global workforce and how to engage with a workforce that does not share a common cultural and institutional mindset' (Budhwar and Varma 2011: 321).

Bain's *India Healthcare Roadmap for 2025* noted that there were challenges in both health infrastructure and talent as well as significant regional variations in the accessibility of health (Singh et al. 2015). To meet demand,

structural improvements such as a comprehensive scaling up of the educational infrastructure for health have been put forward. In addition, organisations are recognising the need for a greater emphasis on talent management.

The healthcare challenges in India will therefore be met by a combination of government policy and action and organisational emphasis towards human resource management of which talent management is an integral part.

The Role of Leadership Competences and Development in Employee Engagement

The attraction, assessment, recruitment and retention of health sector leaders who have personal insight, professional credibility and an understanding of organisational dynamics are aspects of talent management that are critical to employee engagement. These assumptions are supported by a study of employee engagement in the UK (Macleod and Clarke 2009) which concluded that 'the best ways of increasing engagement levels in the UK is to ensure more leaders understand the concept and what it can deliver'. The implication is clear. Ensure that there are leaders who understand the link between their own performance and employee engagement and have the knowledge, skills, attitudes and behaviours to implement an employee engagement programme. The competences against which these processes take place should reflect contributors to employee engagement, and the development of leaders against these competences will form the key area of talent management. There is evidence in support of these points in health sector research.

Leadership was found to be a key contributory factor to employee engagement geographically in studies in Portugal and the USA (Salanova et al. 2011: 2256) and in professional groups where leadership was key to collaboration and team building, two important factors in generating engagement (Opollo et al. 2014). These findings indicate the need for individuals in leadership positions who have the

competences to take ideas across teams, adopt empowering behaviours, foster participation in decision making, and provide autonomy and freedom from bureaucratic constraints (Cziraki and Laschinger 2015).

Identifying leadership competences, gaining board-level commitment to them, making them part of a range of talent management processes and ensuring that they are sustained throughout the organisation fall within the sphere of talent management. The 'checklist for acquiring talent for learning' (Ulrich and Ulrich 2011: 201) might include developing talent internally with these or hiring new employees against a new competence set; organisational recognition of the importance of learning with particular reference to the competences related to meaning at work, pride and integrity; and focusing on the application of the competences rather than seeing them as knowledge alone.

Where the leaders of the organisation demonstrate these competences and through so doing ensure that health practice excellence is delivered into the working environment, the effects on employee engagement can be transformational (Harris and Cohn 2014).

The impact of talent management on mission fulfilment, for example, will require that those who achieve board or executive roles do so by having an understanding of the relationship between mission and engagement and have attitudes and behaviours that are consistent with the organisation's mission (Weimer-Elder 2013). The talent management influence is therefore one of developing the right competences and making sure that these are included in recruitment or assessment decisions for the appointment of talented people into positions of leadership. This will be complemented by providing leadership development for the knowledge, skills, attitudes and behaviours for engagement. The outcome will be leaders who 'will be better poised to cultivate a work environment in which employees are spirited and engaged to excel' (Merisalo 2015: 10). This assumption reinforces the necessity of ensuring consistency between talent management objectives, language, systems and processes and other HR processes such as recruitment.

The implications of this assumption are ones of empowering health sector leaders to create an environment for engagement but most importantly

Drivers of employee engagement	Talent management activity		
	Leadership Development	**Management Development**	**Whole Workforce Development**
Mission fulfilment: shared purpose and values	assessment of leaders to include the importance of employee engagement ; values based leadership development to reinforce engagement leadership competence includes the ability to create an environment of engagement competence development based on communicating vision and translating to operational objectives	assessment and appointment of managers who are able to execute shared purpose and promote shared values management competences and training to include emphasis on engagement appointment and development of managers who are themselves engaged	workforce development activities that include deployment of mission and an emphasis on purpose clarification of mission during onboarding and mentoring team based development to complement individual programmes
Meaning, pride and the work environment	appointment of leaders and managers who can convey the concept of meaning at work leaders with self- knowledge and emotional intelligence leaders with awareness of impact on others empathetic approach	engaging through teamwork creating meaning at work for team members	emphasis of vocational aspects of health professional roles; assess and recruit accordingly educational programs emphasizing constructive culture styles job rotation for development and engagement encouraging cross functional collaboration to develop individuals and to break down barriers
Relationships, empowerment, employee voice and trust	Leaders who have the ability to engender trust in what the organisation is trying to achieve and how it goes about doing so. Leadership development that includes employee engagement providing mechanisms for leaders and managers to listen employee issues over learning and career	line -manager development that includes employee engagement build in social capital aspects of recognition, trust and social reciprocity to management development aware of systems and processes that drive the organisation	providing employees with practical steps to shape their career and to air a point of view about short and long term options
Career and professional development	Creating an environment for career enhancement by allowing career 'moves' and resources	Encouraging team members to develop and manage their own careers Providing support for career moves Acting as a career role model	A health workforce that recognises, has access to and takes advantage of development opportunities; provision of career paths for the short term; provision of joint career conversations and information All employees have a learning and career plan; Recruiting health professionals who have learning skills and can engage through proactive career development

Fig. 10.2 The practice of aligning talent management and employee engagement in the health sector

to ensure that they have the skills to encourage and implement career development plans (Goh and Lopez 2016), a prime objective of talent management. Figure 10.2 summarises the talent management activities required for leaders and leadership development.

Integrating Employee Engagement Characteristics with Management Development

Brewster et al. (2015: 578) have argued that 'it is difficult to see how managers, the people who are responsible for getting things done through others, could not have human resource management responsibilities'. This reinforces the point of view that there exists a symbiotic relationship between HRM professionals and line managers such that effective collaboration between both parties will be an enabler of the implementation of HRM practices, which are 'positively perceived by employees and encourage them to reciprocate by enacting desired behaviors' (Alfes et al. 2013: 853). Further research has shown that overt and implicit signals from organisational practices, many of which are interpreted by line managers, are important to the strength of feeling of obligation on the part of employees which can lead to positive behaviour which in turn will result in higher levels of engagement (Rees et al. 2013). These assumptions reflect the importance of effective line managers to employee engagement. There are similar implications for talent management.

The role of line managers was identified as one of the four drivers of employee engagement in a report commissioned by the UK government (MacLeod and Clarke 2009) and in studies of the effects of work relationships on engagement in, inter alia, China, Australia and the USA (Brunetto et al. 2013; Fan et al. 2016). Line managers who are engaged with the organisation will be positively regarded by employees who are more likely themselves to be engaged because 'it seems that people are more likely to believe and trust what leaders say if they feel those leaders really believe in what they are saying themselves' (Smith and Macko 2014: 60). Where this is the case, effective line managers can have a positive impact on employee well-being and engagement, turnover and retention (Brunetto et al. 2013; Krishnaveni and Monica 2016; Teoh et al. 2016).

In the health sector, managers played a pivotal role in engaging their teams towards the goal of excellence (McSherry et al. 2012), and those who recognised the importance of empowerment and support of individuals, thereby leading to an engaged health workforce, saw job tension decrease

and effectiveness increase (Cziraki and Laschinger 2015). Health managers have a pivotal role in managing change, decision making, problem resolution, people development and meeting their unit, departmental or organisational targets and at the same time managing the potential tensions because 'their dual professional role might be a concern for medical managers whose professional identity might struggle with the motivation in pursuing managerial activities and organisational goals' (Macinati et al. 2016: 1017). An understanding of the nature of this support is a critical factor in determining talent interventions to enhance the role of the line manager as a mediator of employee engagement.

Using Seijts and Crim's (2006) critical factor analysis, possible interventions to enhance employee engagement in health by management development will include the following:

- Developing communication skills firstly to articulate the vision of the organisation or the objectives of the unit, department or organisation; secondly to demonstrate that managers value their team members; and thirdly to clarify what is expected of employees and to provide feedback as to how they are performing
- Providing support for talent management initiatives with respect to whole workforce development, particularly in the field of career management and outlining career paths
- Demonstrating their professional credibility in the health sector context
- Generating confidence in the organisation through high standards for performance and ethics.

Turner and Kalman (2014: 213), in proposing that 'good management is good talent management', argued that the greater expectation on the part of employees about career opportunity and development would require managers to be active in the processes of talent management. Hence, the symbiotic relationship between line managers and HRM could be equally argued for talent management. In this respect, it is important to have managers in health sector organisations who, by their active interest in the career development of their team members, contribute to a significant factor in employee engagement. To achieve this will require, in

a way similar to that for leaders, a process whereby managers are recruited and developed against a set of competences which include ones related to talent management such that 'education programmes for both managers and professionals in hospital settings, and also for managers to bring into practice at workplaces by working with recognition, trust and social reciprocity' (Strömgren et al. 2016: 124).

Whole Workforce Development and Employee Engagement

Workforce development is a priority across many sectors because of demographic forces which are making development an imperative (Warren et al. 2015) and the necessity to deal with the shift in roles (such as nursing) from the present to the future (Bennett and Alliex 2014). In this respect, talent management that is inclusive and engages the whole workforce will contribute to sustainable and effective people development which in turn will encourage organisations to optimise their application of all of their talented employees, which in turn will enhance the meaningfulness of work pride in that work and a positive working environment. Hence, 'the key to better talent management … is to give both the employee and the employing organisation tools to better match what the employee needs and what the organization requires in terms of performance' (Schein and van Maanen 2016: 165).

An important aspect of whole workforce development concerns the provision of career development opportunities and career paths. The implications of research was the recommendation that, based on the assumption that health professionals have both a vocational and organisational commitment to career development, then health sector organisations should create both the motivation and opportunity for development through efficient career management systems (Kim et al. 2016). In support of this, vocational interest influences behaviour 'by motivating the choices that individuals make regarding the amount of involvement and effort they put into certain tasks and activities' (Johnson and Beehr 2014: 100); where there is a congruence of employee interest

with their work environment, this would have a positive effect on engagement with both the career opportunities on offer through, for example, whole workforce development, and the level of engagement with the organisation. Further research has shown that one aspect of vocational interest (i.e., investigative) was an important indicator for employee voluntary participation in continuing professional education (Johnson and Beehr 2014: 107).

Talent management can be an important tool in enhancing these relationships. In a Norwegian study, for example, it was concluded that 'the findings also showed that work engagement among nurses increased proportionally with their experience and professional development, something which strengthens the pre-supposition that resilience is a normal state-like factor which it is possible to develop The findings also showed that work engagement among nurses increased proportionally with their experience and professional development, something which strengthens the pre-supposition that resilience is a normal state-like factor which it is possible to develop' (Bjarnadottir 2011: 33). In this case, the professional development of clinical staff, maximised by the organisation's commitment to whole workforce development, would be an important contributor to the wider objective of employee engagement.

However, a nuanced approach to the formula for linking career development and employee engagement was found to be the case in a study of the British NHS (Philippou 2015) where a temporal dimension to careers was identified. In this, short-term responsibilities for providing career development funding were perceived to reside more with employers. In the medium term, activities such as assessments of job-related knowledge and skills and identifying subsequent education and training needs were shared between employer and employee. Other mediating factors in career development will be generational differences (Lissy and Venkatesh 2014; Eastland and Clark 2015: 56; Havens et al. 2013) and the importance of team (Van Bogaert et al. 2012; Weimer-Elder 2013; Havens et al. 2013; Fan et al. 2016).

Finally, there is the consideration that 'long-term responsibilities for developing individual careers and future development plans lay primarily

with employees' (Philippou 2015: 78) with the conclusion that health sector employees should be given independence to plan their careers accompanied by a flexibility in approach for employers. In this respect, the concept of *career anchors* is important 'for understanding this process and, therefore, is an important way to conceptualize the *adult* career' (Schein and van Maanen 2016: 165). How to achieve these career anchors in health, thereby cementing the effectiveness of the links between talent management and employee engagement, is important. From this perspective, the ability of an employee to perform effectively, to deliver objectives (Mensah 2015: 557) will not only be require empowerment to effect the agreed tasks of a particular role and channels by which issues can be resolved.

Conclusions and Implications for Practice

These findings give an indication of the potential of employee engagement to influence performance and to impact on a range of outcomes. In this context, talent management can be a compelling intervention to enhance the process (Chaudhary 2014: 153). Links between talent management and employee engagement are direct—'employee engagement begins with developing talent. Leaders should be on the lookout at all levels of the organization for talent that can be cultivated, and they should make sure those employees receive coaching and mentoring only from the managers who are skilled in developing talent' (Decker et al. 2016: 6)—and more tangential, embracing a wide range of talent-associated activities such as learning training and development or career management.

Given the possible number of touch points between talent management and employee engagement, the priority facing health sector organisations is to establish their own definition of employee engagement (i.e., best fit rather than best practice), identify where the points are, and by combining the two develop a better understanding of the drivers of employee engagement and how talent management can contribute to them. Since the touch points are likely to contain strategic elements such as the organisation's mission and values as well as operational matters such as the

employee value proposition, the working environment, the constitution of teams and the methods in which organisations communicate with their employees and elicit feedback from them, the scope of employee engagement will include all organisational levels. Employee engagement will therefore have the same 'pluralistic' criteria as those of the talent definition. In a pluralistic approach to talent management, there will be a focus on most members of the organisation, and indeed in both public (Powell et al. 2012) and private sector health organisations there may be a duty to do so with the positive impacts on equality and diversity. If 'talent' exists at every level of the organisation, then the approach to employee engagement will have a broad perspective. It is possible to identify four key areas where talent management can have a positive impact on the organisation's ability to engage its workforce.

So, whilst employee engagement is often associated with concepts such as job satisfaction, job involvement and organisational citizenship behaviour (Kaliannan et al. 2016), it also has a relationship with talent and talent management. In hospitals, the highest positive value of the correlation between HR practices and job satisfaction suggests that a particular focus should be on both training and development and selection, and whilst a myriad of factors influence health worker motivation, opportunities for development stand out (Didem and Zümrüt 2014; Hotchkiss et al. 2015). Establishing the nature of these links and how they interact with one another is important because employee engagement has an impact on both individual and organisational performance.

Employee engagement is an important aspect of people management and development in health sector organisations. An engaged workforce can have an impact on a range of strategic and operational variables from the achievement of overall organisational objectives to better patient care and operational outcomes. But as the above narrative demonstrates, employee engagement has multiple antecedents, is dependent on a variety of organisational relationships and is likely to be an organisation-specific phenomenon.

The relationship between talent management and employee engagement can be direct—such as leadership development to include 'engagement' competences and awareness—or indirect or even tangential by creating an environment of efficacy amongst health workers through

training, development and the creation of career opportunity. There is evidence that where effective career management and systems are in place, there are the foundations for engaging the workforce, although the strength varies from circumstance to circumstance and from organisation to organisation. But it isn't only in this area that the relationship exists.

In aspects such as creating meaning at work, developing an environment of trust and building effective teams, the role of leaders and managers is of paramount importance. Talent management interfaces with these points at the attraction and assessment stage by identifying people with the right competences to ensure organisation-person fit. Engagement factors and talent management also come together when identifying competences for leadership or development programmes which would include some of the points indicated by research as being of importance and these will include, once again, the ability to create meaning at work, the ability to collaborate with peers and the ability to create high-performance teams to deliver in challenging environments. Each of these reveals a link between talent and employee engagement, although some are more tangential than others.

The research gives some important indicators for practice when looking to strengthen the relationship between employee engagement and talent management:

- In the first place, it is important for organisations or groups of organisations to clarify what is meant by employee engagement in their specific environment and circumstances. A clear definition will facilitate the allocation of resources, provide a common language, and—most importantly from the perspective of this book—help identify areas of commonality or overlap with those of talent and talent management.
- Once the definition is agreed, the drivers of employee engagement can be identified. The above narrative gives the experience and perspectives of many organisations from around the world. And whilst there are commonalities, there are also some striking differences. It will be necessary for each organisation to have an understanding of the drivers of employee engagement in its own specific context.

- At this point, the areas where talent management can improve performance against each of these drivers can be identified and action plans put in place.
- For many organisations, the most straightforward linkages between the two will be in areas of leadership assessment, recruitment and development where competences against the drivers of employee engagement can be used to identify, appoint or develop current and future leaders.
- In a similar way, the selection and development of managers can use these competences as a foundation.
- Finally, the role of career and professional development in engaging health sector employees has been shown to be important in many, but not all, instances. Talent management will be able to support career processes and systems which are aligned to both the achievement of the organisation's objectives and the drivers of employee engagement with beneficial effects on both areas.

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11

Retaining Talent in Health Sector Organisations

The Importance of Retaining Talent

The case for linking employee retention and talent management in health is one of improved knowledge and skills, which in turn will lead to improved performance which in turn will lead to a more motivated, engaged workforce more likely to stay with the organisation.

But the challenge of retention in the health sector is global, applying to underserved regions; middle-income countries, where robust economic growth leading to an increase in demand may not be matched by the timescale of supply (Liu et al. 2016; Li 2016; Blumenthal and Hsaio 2015; Sun et al. 2016; The Economist 2016); and high-income countries (Carson et al. 2015), where there are regional disparities and strong competition to attract and retain talented healthcare workers.

Retention is defined as the extent to which an employer is able to keep employees in the organisation; and it can be expressed as the proportion of employees with a specified length of service as a percentage of overall workforce numbers (Chartered Institute of Personnel and Development [CIPD] 2016a). It is directly related to talent management through career development and progression, two of the key levers used by employers in building up their retention capability because 'when organisations want

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to retain their employees it is important to pay attention to the learning of employees. Letting people do more and learn more of what they are good at will encourage them to stay with the organisation' (Govaerts et al. 2011: 35). The focus on employee retention from the World Health Organization (WHO), National Health Sector bodies and (in particular relation to this study) health organisations is at the primary, secondary and tertiary unit levels.

The contribution of talent management to employee retention has been demonstrated in the US 'magnet hospital' model where the planned orientation of staff, competency-based clinical ladders and management development have created an environment in which such hospitals have performed better than average and had lower reported turnover and vacancy rates and higher job satisfaction (Upenieks 2005: 22). Furthermore, the outcomes of talent management (including speciality qualifications and clinical career development programmes) prepared nurses better for changes to the health environment such as evidence-based practice (Wilson et al. 2015). This conclusion gives support to the assertion that attractive hospitals provide opportunities for professional development (Peltokoski et al. 2015: 955). Hence, linking employee retention and talent management has the potential to improve the performance of the organisation and engagement of the individual.

The organisational case is one of reductions in the tangible costs of high turnover, such as hiring new employees or the costs of disruption to operations, and intangible ones such as loss of organisational memory (Al-Emadi et al. 2015), practice knowledge or in some cases intellectual property. The cost of turnover puts value at risk (Willis Towers Watson 2016), and the economic argument is further reinforced because of the high investment in skilled health professionals: for example, investment in hospital physicians in the USA, which is of the order of US$150,000 to US$250,000 per year over the first three years 'due to a slow ramp-up period as physicians establish themselves or transition their practices and adapt to management changes' (Block 2016: 44). The return on this investment only comes over time, and the positives from retention relate to both knowledge and economics. Indices such as the investment-based pivotal employee turnover index, which measures the ratio of the compensation investment lost when pivotal people depart

divided by that of all employees and which is used to derive retention risk scores (Frigo and Ubelhart 2016), show that turnover and retention are of strategic importance.

Employee Retention Is a Global Issue

At the supranational level, the WHO uses policy levers to shape health labour markets and, because of persistent health sector workforce challenges, has highlighted those that contribute to retention as of particular importance, noting that retention will require transformative advances alongside a more effective use of existing health workers (WHO 2016). At this and national levels, the retention of talented health workers is dealt with by policymakers (Paina et al. 2016), and over the years a range of voluntary and compulsory retention programmes have been put in place. By 2010, more than 70 countries had adopted these processes (Frehywot et al. 2010). However, at the organisational level, retention is based on practical interventions that are aligned to the overall strategy and backed by operational processes and effective implementation. There is also an important link between these initiatives and talent management, and an effective combination of both will enhance the chances of addressing critical business outcomes and contribute to the success of those outcomes (Douthitt and Mondore 2014).

Employee retention is important across the range of healthcare professions. Nursing turnover and shortages had an impact on healthcare cost, job satisfaction and patient care (AbuAlRub et al. 2009; O'Brien and Ackroyd 2012; Van den Heede et al. 2013; Lartey et al. 2014; Scammell 2016), and it was argued that retaining experienced nurses would help 'to mitigate the shortage, facilitate the transfer of knowledge and provision of quality care to patients' (Lartey et al. 2014: 1027), whilst the failure to retain nurses could have a deleterious effect on service delivery (O'Brien and Ackroyd 2012). Effective retention was also seen as a way of addressing the shortage of rehabilitation professionals which was 'considered to be challenging all over the world' (Tran et al. 2012: 32) and of resolving the inequitable distribution of doctors between rural and urban areas (Pagaiya et al. 2015). Amongst community health workers

in Mozambique and Uganda, retention is one of the key constraints to the success of programmes in line with the WHO's health aspirations (Llewelyn Strachan et al. 2015); and in both Kenya and Thailand, retention was shown to be a significant challenge because of health-care worker shortages and the rapid expansion of the primary health-care infrastructure (Ojakaa et al. 2014; WHO 2013: 9). Retention is therefore a challenge in large metropolitan areas where competition for talented health professionals is likely to be fierce and in rural and sparsely populated areas where it is a persistent problem as shown by research in Australia, Canada, South Africa and the USA (Carson et al. 2015).

Before an organisation is able to deal with employee retention through talent management, it is important to identify those elements that will have the most impact.

The Constructs of Employee Retention

Retention is bound up with the complexity of relationships both between employees and between employees and the organisation. Previous chapters have discussed the forces that contribute to satisfaction or dissatisfaction; motivation or demotivation and engagement or disengagement which presented a multi-layered relationship based on values, economic, political, and social status or aspirations; career aspirations; and the need for balance, not only in work life but in work, life and career. Four broad areas of the relationship were identified: financial rewards, such as income and benefits; organisational context, including resource availability; other people, including satisfaction with patients and colleagues; and the nature of the work itself, such as how mentally stimulating the work is and whether it is varied or monotonous (Ashmore and Gilson 2015: 2). The richness in the factors considered under the subject of workforce engagement is equally important when considering that of employee retention.

Two important constructs stand out. The first of these is human capital theory, which puts forward the view that stay or leave decisions are based on a cost-benefit equation in which the employee assesses current

value against potential gains from leaving the organisation. Research on human capital has taken place at the micro (psychology and human resource management) and macro (organisational, associated with competitive advantage) levels in relation to how organisations can retain their most talented employees (Coff and Raffiee 2015). The second construct is social exchange theory, which focuses more on the organisational environment such as empowerment and fairness of treatment or support. In this point of view, 'psychological contract fulfilment is important to the employment exchange because it reflects employee beliefs, expectations and perceptions about the extent to which mutual obligations (implicit promises) between an employee and employer have been satisfied' (Birtch et al. 2016: 1217). Where the employee assesses that the current state of this support exceeds the potential from another organisation, they will make the decision to stay (Al-Emadi et al. 2015).

There is commonality between talent management and employee retention in that both human capital and social exchange theory feature strongly. And as such, talent and retention strategies for health will require crafting in such a way that takes account of both in the specific context of the organisation and the unique needs of the health professionals who work in it (Lewis and Heckman 2006; De Vos and Dries 2013; Gallardo-Gallardo et al. 2015). Additional factors, some of which are unique to health, are labour market economics and the nature of supply and demand in the national or international health sector workforce and psychological factors such as the attitude of health sector workers to their jobs or working environment (Loan-Clarke 2010).

A final consideration acknowledges differences in retaining employees in the public sector where there are challenges due to constrictions in flexing remuneration packages and limitations in the provision of career or job development opportunities (Al-Emadi et al. 2015). To address this, the WHO has advocated a 'decent employment agenda', which is an integrated package of gender-sensitive retention policies which include job security, a manageable workload, support from supervisors and managers and—of particular importance for the employee engagement/talent management agenda—'continuing education and professional development opportunities, enhanced career development pathways … and education allowances and grants' (WHO 2016: 14).

Hence, it is possible to see employee retention through a broad interdisciplinary lens which takes account of human capital and social exchange theories but also includes elements of labour market economics. The importance of this broad perspective is highlighted when considering one of the traditional assumptions about nurses and other health caregivers and the prosocial forms of motivation, which means wanting to help others in an altruistic way. For example, a consistent theme of career success and satisfaction in the dietetic workforce studied over a ten-year period in the USA consisted of intrinsic factors (helping people, being effective in one's job, being acknowledged as a specialist) more than extrinsic factors such as remuneration and management progression (Plint et al. 2016). However, whilst this was an important factor and contributed to the concept of meaning at work, which will be discussed later in the chapter, both intrinsic ***and*** extrinsic motivational factors in combination were important considerations.

Why People Stay with Health Sector Organisations

Research has shown a variety of factors in the decision to stay with a particular organisation, including job satisfaction, extrinsic rewards, organisational commitment, and organisational prestige. Amongst other positive drivers of retention were flexible working, leading to positive discretionary behaviour, and a number of performance outcomes (Atkinson and Hall 2011), including stability in leadership and the importance of continuous development of employees, effective communication at all levels, and team-building activities aimed at contributing to the morale of the health workforce (Curson and Parnell 2010). Employees will stay with an organisation in which there is an environment of encouragement and motivation, in which reward is perceived to be of sufficient value to satisfy needs and aspirations and in which there is a harmonious, healthy working environment (Al-Emadi et al. 2015). Additionally, allowing health workers, such as registered nurses, to practice at the top of their professional standing (Berlin et al. 2014) leads to

higher job satisfaction and lower staff turnover and 'when nurses view their employer as having fulfilled promises made to them, nurses are more satisfied and more likely to be committed to their organization and the nursing profession' (Rodwell and Ellershaw 2016: 406).

Autonomy in decision making, effective communication and strong interpersonal relationships (there is a relationship between management style and nurse retention), recognition, and a work environment that encourages a caring approach (one that was conducive to professional practice) are also important (Kuhar et al. 2004; Nassar et al. 2011). These findings feature in the work of West and Dawson (2012) in the British National Health Service (NHS), which showed that the reasons for staying in the organisation included the opportunity to work in well-structured teams and the clarity of the job and job design. Line managers' support and the overall organisational climate were also considered to be important. The study concluded that job satisfaction, organisational commitment, the intention to leave, and the well-being of employees were predictors of organisational outcomes such as effectiveness, productivity and innovation and most importantly the quality of the patient experience (West and Dawson 2012). However, the often contextual nature of stay or leave decisions is demonstrated by findings from a cross-geography study of Yemen, Jordan, Lebanon and Qatar which found that the factors associated with intent to stay differed from country to country but included experience and job satisfaction (El-Jardali et al. 2013).

Why People Leave Health Sector Organisations

Attrition can affect both organisational performance and the wider health system (Steinmetz et al. 2014). On the one hand, the failure to retain could have 'negative consequences for health service accessibility and health outcomes in the affected population' (Buykx et al. 2010: 102). On the other, the effectiveness in retaining talented health workers and giving them the opportunity to maximise their contribution to the organisation's success in a positive, engaged way will contribute to the achievement of the organisation's strategic goals or targets. Therefore, it

is seen as important for organisations to retain talented people with the skills and experience that may have been brought in through successful attraction and recruitment strategies or developed internally through the implementation of leadership, management and whole workforce programmes. If talented healthcare workers leave, the investment in their talent will have been wasted, valuable knowledge lost and productivity affected. This applies from students to doctors in Bangladesh (Darkwa et al. 2015) and rural Thailand (Pagaiya et al. 2015) and the retention of primary care physicians in the UK (Verma et al. 2016). There are immediate effects on the ability to deliver service through the inability to retain talent but there are also concomitant effects on morale and motivation.

The reasons why talented people leave organisations are a mix of push factors, such as dissatisfaction in the working environment, or pull factors, such as perception of better pay, a better job, career or development in another organisation. Addressing factors on both sides of this equation will influence the ability to retain talent.

In a general health setting, the 'feeling of lack of control and autonomy, and the inability to participate in practice and hospital decision making' (Redknap et al. 2015: 268) can contribute to dissatisfaction amongst health workers, which has an additional effect on the ability of the organisation to retain them, whilst research in the Belgian health sector concluded that if organizations wanted to manage turnover of healthcare workers, they needed to understand how to influence the decision-making process whereby nursing staff think about quitting.

Management interventions at early stages in this process could 'reduce such thoughts and stifle the momentum of quitting before an employee develops firm intention to search for a new job' (Derycke et al. 2010: 890). Job dissatisfaction is a prominent determinant; a perceived lack of appreciation or perceptions of not being valued were others, and the lack of career development opportunities and a supportive professional environment would contribute to these Many of the characteristics of employee engagement will also feature in whether talented people stay or leave an organisation. A study of physicians in the USA, for example,

found that these included a lack of engagement with colleagues, poor lines of communication with the leadership or management team, a lack of opportunity to participate in decision making, and a 'general lack of appreciation or recognition for contributions made by the physician to the practice, the hospital and/or health system' (Block 2016: 44). In the British NHS, excessive workload, pressure and stress at work were amongst the main reasons why employees left the organisation (Loan-Clarke et al. 2010), whilst in Romania, health sector workers left their organisations and indeed their country because of, inter alia, a perceived lack of support for training (Paina et al. 2016), a finding which also resonated in Australia (Lincoln et al. 2014) and Ghana, Germany and the USA, where a lack of promotion opportunities was identified as the main retention barrier (Beck et al. 2012; Abuosi 2015; Ognyanova and Busse 2011). In studies of retention amongst health workers in China, factors included perceived lower prestige and recognition than that attributed to

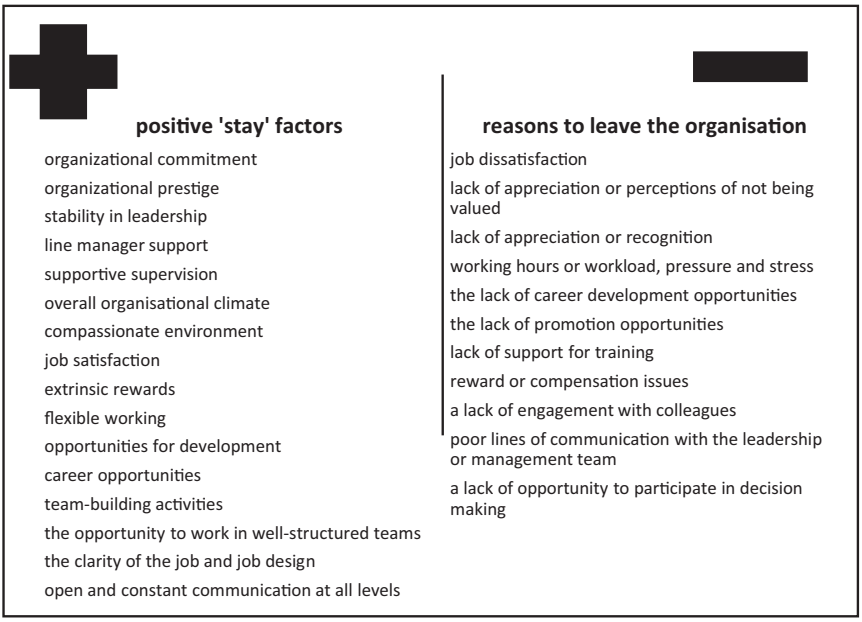

Fig. 11.1 Summary of the reasons why people stay with or leave organisations in the health sector

clinical doctors (Zheng et al. 2015: 245) and personal, social, cultural and work-related factors (Zhou et al. 2016).

Figure 11.1 pulls together some of the above research and shows the force field of those factors that influence the decisions of individuals whether to stay with or leave organisations.

Case Study: Talent Management in the Chinese Health Sector: The Supply-Demand Gap

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Current healthcare services in China are delivered mainly through a three-tier system. At the basic level, the primary care system covers healthcare service provision to residents in rural areas and local communities in towns and counties. Such primary care services are provided by village doctors and health workers in rural clinics and by general practitioners (GPs) in rural township and urban community hospitals (with between 20 and 100 beds). At the second level, healthcare services are provided by secondary hospitals (with between 100 and 500 beds), which act as healthcare centres for districts and provinces, provide professional and technical support to primary hospitals, accept primary referrals, and undertake certain levels of teaching and research. At the top level, tertiary hospitals (with more than 500 beds) in large cities provide healthcare services across districts and provinces. They mainly provide specialist medical services, accept secondary referrals, support and guide secondary hospitals, undertake training and teaching for senior medical professionals, and conduct provincial and national medical research projects.

By the end of 2015, there were a total of 27,587 hospitals in China. With the policy encouragement of the state, private hospitals have been established to enter healthcare services in recent years. The number of private hospitals has more than doubled from 2010 to 2015 and reached 14,500 in 2015, representing 52.6% of total hospitals. However, the majority of private hospitals are positioned at the primary and secondary levels and encounter very high threshold barriers to the top level. Under the hospital grade system, each level is further divided into first, second and third class. Tertiary hospitals have a special class that has not yet been used in practice. Thus, tertiary first-class hospitals are regarded as the best hospitals in China and have expanded rapidly in recent years.

The current supply and demand in healthcare services is severely unbalanced in China. The demand for healthcare services has increased significantly in the last two decades. There are several reasons for this change. First, there has been a sharp rise of non-communicable diseases alongside

rapid industrialisation, heavy pollution, income growth, and food safety issues, and 80% of all deaths are caused by cerebro- and cardiovascular diseases, chronic obstructive pulmonary disease, and cancers. Second, China has had an escalating trend toward an ageing society. In 2010, people older than 60 represented 12% of the total population, while the international standard of an ageing society is 10%. Since 2011, people older than 60 have been increasing by an average of 16.55% a year. Other factors also contribute to the growing demand for healthcare services, such as rapidly increasing consumer wealth and the advancement of universal healthcare insurance.

On the supply side, the number of healthcare professionals is significantly lower, in contrast to the huge population. Between 1980 and 2014, there were fewer than 3 million registered practitioners (including assistant physicians) providing healthcare services for a total of approximately 1.2 billion people (1.38 billion in 2016). In 2011, there were 1.82 physicians per thousand individuals in the population, ranked 80th in the world. The ratio of registered practitioners to patients in 2010 was 1:950, ranked 64th in the world. This ratio means that, on average, each doctor in China needs to serve 950 patients. The same ratio in the USA is 1:390, ranking 32nd in the world. This result indicates that healthcare professionals in China have more than double the workload of the same professionals in the USA.

The annual increase in practitioners is less than half the increase in the number of patients. For example, the number of registered practitioners grew by 3.5% in 2014 while the number of patients increased by 8.4%. Although medical colleges and universities have recruited significantly more students over the last two decades, qualified practitioners have been few (as the pass rate for the national physician qualification exam is very low, at only 22% in 2015). Most qualified physicians were employed in tertiary hospitals, and few of them entered secondary and primary hospitals. A large proportion of unqualified doctors and individuals who did not receive higher-education training have worked in primary hospitals and medical centres. Human resources in the health sector are very unevenly distributed, as high-quality practitioners have gathered in tertiary hospitals, particularly tertiary first-class hospitals. Tertiary first-class hospitals have been crowded with a huge number of patients every day, while other hospitals have fewer patients. There were 776 tertiary first-class hospitals in 2015, which could not cope with the huge demands of patients.

The scarce human resources in the health sector are very unstable as well. Approximately 60% of medical graduates have left their medical careers because of heavy workloads, low salaries, and worsening working conditions; salaries are relatively low in comparison with those of some other professionals and even technical workers.

The number of medical treatments in private hospitals is very low and accounts for only 12% of the total number of hospital treatments. There

were 1,035,000 beds in private hospitals in 2015, representing 19.4% of the total hospital beds. Although the state has supported private hospitals through various policies, treating them with an almost equal status to public hospitals. Private hospitals are struggling to recruit and keep doctors and nurses. Very few medical graduates are willing to work for private hospitals. Existing medical professionals in private hospitals face obstacles in their career development. For example, promotions for junior doctors to senior positions are mostly dependent on the number and quality of medical journal papers, but private hospitals have difficulty obtaining national-level publicly sponsored research projects. With fewer career development opportunities, the loss rate of key doctors and nurses in some private hospitals is as high as 40–50%.

To rebalance the supply and demand in the health sector, more fundamental reforms are needed in the future. Talent management is a key task in the systemic reforms. First, more trained and qualified healthcare practitioners are urgently needed to meet the increasing demand of patients every year. Measures should be taken not just to produce more medical graduates but also to enable them to become qualified doctors. Second, the retention of doctors and nurses in hospitals, particularly primary and secondary hospitals, is a key challenge. This need should be considered systematically in line with the state policies in terms of workload, pay and reward, and workforce safety systems for the entire healthcare sector. Third, more qualified healthcare professionals are particularly needed for primary hospitals, community medical centres, and rural clinics to ensure quality medical services at the grassroots of the healthcare system and to win the trust of patients, thereby reducing the workload of large hospitals and the costs of patients who travel directly to large hospitals.

The Relationship Between Talent Management and Employee Retention

The complexity of the factors that influence employee retention in health will require a multi-faceted approach and 'a bundled package of multi-dimensional incentives' if it is to be successful, a point that would apply to health sector organisations in many geographies (Zheng et al. 2015). The package is likely to include elements of talent management as well as broader HR levers such as reward and recognition. But the challenge is compounded by the many definitions of talent management (Lewis and Heckman 2006; Collings and Mellahi 2009; Tarique and Schuler 2010; Vaiman et al. 2012; Meyers and van Woerkom 2014; Sparrow and

Makram 2015; Cascio and Boudreau 2016) which invariably include retention as part of the talent 'proposition'. The thing that most have in common is agreement that the rates and costs of workforce turnover can be prohibitive to performance such that 'when a high-performing employee leaves there is a loss of investment and a reduced ability to achieve organizational goals equalling 150% of that employee's annual salary' (Craig 2015: 206).

For some organisations, this means a focus on internal mobility and development based on the ability to retain those with high potential and clear retention policy associated with talent management; 'there are indicators that talent management can especially help in retaining talented employees and motivating them to stay with their organizations, and thus reduce staff turnover rates' (Festing and Shafer 2014: 266). But whilst the intent is specific (i.e., to keep talented members of the workforce), the actuality of how this takes place is less so and the phenomenon-driven nature of talent (Gallardo-Gallardo et al. 2015) means that each organisation will craft an approach based on its unique circumstances. Since 'retaining employees is increasingly arduous as the demand for highly talented performers becomes more egregious' (Craig 2015: 206), identifying the levers of talent management and designing interventions that will increase the ability to keep talented people will be seen as an important part of the talent strategy.

The levers will differ depending on the (phenomenon-based) approach to talent adopted. If there is an exclusive talent perspective, the levers will be related to those individuals for critical positions and put in place specific actions designed to their unique requirements (leadership development, executive coaching, or career secondment). Where there is a more inclusive or pluralistic talent approach, the levers will be a positive working environment, learning opportunities for those with a learning orientation (closely associated with the intention to remain (D'Amato and Herzfeld 2008)), enlightened managers who are engaged with talent management, a strong employee value proposition and employer brand (Rathi and Lee 2015), and measures to ensure that retention is at a level to support both individual aspirations and organisational objectives.

Talent management processes can apply to whichever definition is adopted by the organisation but will have to be nuanced to the specific

context and ensure that such things as generational effects and their impact on individuals (the strong interest of Generations X and Y on career development and advancement cited as the most significant factors affecting retention rates (Festing and Shafer 2014; Oladapo 2014)) are taken into account.

In addition, it is possible to identify specific retention activities that may be put in place and these will include creating meaning at work and enhancing the ability to execute and develop a professional role and professional identity (Sercu et al. 2015). Further aspects of talent management closely linked to retention are team development and leaders and managers who are competent in the factors that contribute to retention and developed accordingly. However, it is in the area of career and professional development where the links between employee retention and talent management are the strongest and it is to this area where most of the attention will be given.

A Multi-Layered Approach to Retention

The analysis of retention experiences and drivers within an organisation provides information and insight about developing retention strategies as part of the overall approach to talent management. This will have two elements. The first will have a broad perspective covering several different but interlinked sets of actions. The second will be at the operational or execution level because there is evidence that for success in retention 'effective interventions need to match health workers' preferences and expectations' (WHO 2013: 16), which will require an in-depth understanding of those things required to engage and motivate the health workforce.

The necessity of a multi-layer approach to retention strategy can be exemplified by the experience in the Zimbabwe health sector, whose approach to retention included a salary review, payment of top-up allowances, support towards post-basic training and development, improvements to workload by the mobilisation of more health personnel, and non-monetary incentives (Taderera et al. 2016), and in Nigeria, where

improvements in retention would require financial and non-financial incentives, improved health systems and supervision as well as greater job security and a career structure (Adegoke et al. 2015). The British NHS synthesised the challenge of retention by highlighting four critical approaches for their talented health workers (NHS 2015) and their findings resonate with those of other regions. These were based on the assumption of the necessity of a clear strategic rationale for employee retention strategy and policy in order that efforts could be targeted in the most appropriate way. These were consistent with earlier research into global talent management undertaken by Turner and Kalman (2014). It is possible to synthesise these findings and others from the experiences of healthcare organisations around the world into four key areas of concern which are shown in Fig. 11.2 and may be summarised as providing meaning at work, providing career and development opportunities, rewarding for performance, and rewarding for satisfaction and excelling through culture and a positive working environment.

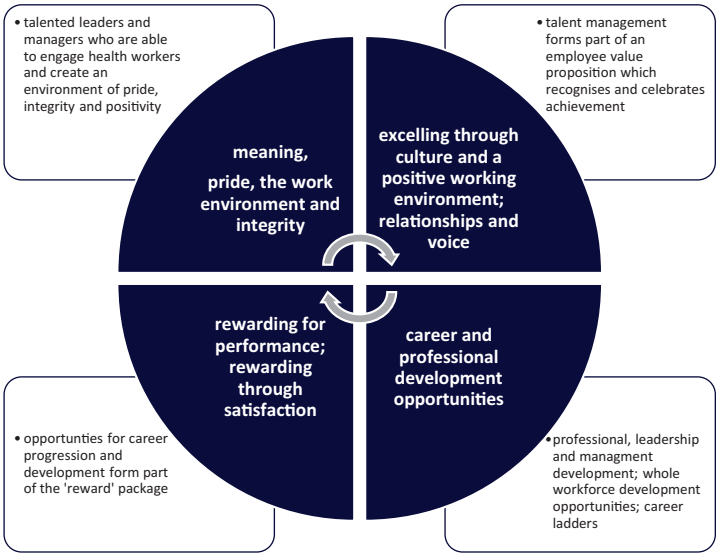

Fig. 11.2 Four characteristics of retention and talent in healthcare: a multi-layered approach

Providing Meaning in Health Sector Organisations

Creating meaning at work is one of the constructs on which to build an approach to retention. This is aligned to the employee value proposition, the development of which was an important characteristic of employee engagement and defined by West and Dawson (2012) in the context of the British NHS as a positive attitude held by the employee towards the organisation. At its most powerful, an employee value proposition that includes meaning can 'yield employees who are more productive and committed, who build the organisation's capacity to respond to business challenges, and who help their organisations succeed' (Ulrich and Ulrich 2011: 262); in this context, meaning at work is that which motivates, inspires and defines an employee in the working environment since, it is argued, those who find meaning at work can find meaning in life (Ulrich and Ulrich 2011).

Meaning at work in the health sector is related to the nature of both professional role and professional identity (Sercu et al. 2015). It is framed as a balance between humanistic and medical aspects of the role (Kamp and Dybbroe 2016), and research has identified two important discourses in the creation of legitimate meaning in healthcare: around the 'patient' and the 'healthy citizen' (Waldorff 2013: 283). In a study of the health sector in Denmark, it was found that effective discourse had 'the potential to be translated into practices when the involved actors are able to argue that the discourse resonates with the local context' (Waldorff 2013: 305). However, this could take place only when health professionals, including those in leadership or managerial roles, were given the opportunity to participate in the process of meaning creation.

And whilst occupational value orientations have not been completely aligned with occupational choice (Benditt 2015), it can be assumed that a value such as compassion is an important constituent of meaning at work for many health sector professionals. Ensuring space for compassion as part of the professional role can be the basis of retention with the organisation.

'The development of compassionate and caring therapeutic nurse–patient relationships; integrating nursing theory into practice; and the ability for nurses to use their perception, thoughts, and feelings in the

identification of patient needs' (Redknap et al. 2015: 262) perfectly encapsulate the concept of meaning at work in the health sector.

These studies show that meaning in the health context is based on the ability of the health sector worker to create effective practices to deliver positive patient outcomes (professional role) and that the role allows the professional to have a discourse about how this takes place and can apply knowledge and skills in ensuring its delivery and this is done in an environment of humanism which has the support of all of the 'actors' in the health sector organisation (professional identity). The experiences of employees 'are of importance for many people for their own sake'.

Providing Career and Development Opportunities: 'Trust Is Future-Oriented'

The availability of career opportunities features strongly in the literature about retention in health (Parsons and Stonestreet 2003; Block 2016; Verma et al. 2016). In this respect, a career can be defined as a sequence of a person's work experiences over their working life which implies a career path involving a series of moves over time with clear linkages from position to position (Harris et al. 2015). The two important criteria are the constructs within the organisation to provide career opportunity and for the individual 'career adaptability which has been defined as the capacity to adapt, is an important consideration in the subject of retention.' The construct of career adaptability is based on career concern, career control, career curiosity and career confidence (Coetzee and Stoltz 2015: 85).

Rodwell and Ellershaw's study of retention in the Australian nursing sector concluded that 'trust is future oriented and that individuals base future reciprocation (i.e., organizational commitment) on past experiences' (Rodwell and Ellershaw 2016: 411). This has two implications for talent management. The first relates to the present in that the availability of opportunities for development will be critical to retention. But the provision of career paths will be equally important. Indeed, research has found that 'individuals' human capital as assessed in the first stage of the career was positively related to individuals' performance

in the second stage of the career' (Harris et al. 2015: 110). Health sector organisations, faced with the challenges of retention and the potentially deleterious effects on performance, will seek to ensure that their career opportunities are sufficiently attractive to persuade talented professionals to stay.

Providing the opportunity for career development and having the ability to put this into practice are often cited as ways of retaining employees at all levels of the organisation. Ultimately, this should be a shared experience that will benefit both health sector employer and the employee (Philippou 2015). A systematic view of retention strategies found some evidence of high levels of retention through professional development offerings in the UK (75% from the London Academic Training Scheme (Verma et al. 2016: 20)), and a proposal to deal with the serious challenge of ensuring long-term physician numbers in Japan caused by shorter retention periods for younger physicians was to create a revolving-door type of career path between public health departments and hospital clinical departments providing easy re-entry to either area (Koike et al. 2010).

A study of critical success factors in promoting careers of allied health workers in the USA included practical training *in situ* such as through internship, cross-training among disciplines and formalised mentoring (Reddick et al. 2013). This last point was an approach that has been used to provide guidance on the achievement of career goals in an Australian context where mentoring was identified as having the potential to create a satisfied health workforce and one in which individuals could achieve their career goals (Bourke et al. 2014). Mentoring had the twin outcome of enhancing the skills to do the job and motivating to stay in the job.

Rewarding for Performance, Rewarding Through Satisfaction

The term reward has both extrinsic (usually financial) and intrinsic characteristics that are important in retention. Firstly, monetary reward is amongst those factors that have the ability to influence job satisfaction and thereby greater organisational commitment of health sector workers

(Hsu et al. 2015). But intrinsic reward such as personal gain and satisfaction with the outputs of the work (Gardner et al. 2014) can also be powerful retention factors. It is for these reasons that reward features strongly in analyses of the reasons for retention difficulties (Alameddine et al. 2016) and as a potential solution to retention problems. Both the level of reward and satisfaction with reward—which can also be called the perceived effort-reward balance (Derycke et al. 2010)—are important. Research amongst health workers in Belgium, Germany and The Netherlands found that employees with a low level of reward (wages) or low satisfaction with rewards were less likely to express an intention to stay with an organisation, but it was not just the level of wages that were the determinant but also wage satisfaction (Steinmetz et al. 2014). This reinforces the need to adopt a comprehensive, strategic view of reward that not only takes account of short-term needs or aspirations but is aligned to the organisation's objectives.

At an operational level, extrinsic reward will be concerned with pay and pay structures. But an approach which takes into account factors from both human capital and social exchange theory may include intrinsic factors such as work-life balance and flexible work arrangements. The challenge is to redesign incentives that inspire and motivate the whole workforce (Solnet et al. 2012). In this respect, the concept of total reward as a way of retaining talented employees might include the traditional elements of pay and benefits packages but also flexible benefits, access to professional and career development, recognition of achievements and matters relating to the working environment as well as flexible working hours (CIPD 2016).

The reward strategy as key contributor to retention will be a mix of cash or wages but also non-financial rewards; the principles of best fit will apply since each organisation's context will have to be taken into account when determining the key elements and it will combine both strategic (rewarding those things that contribute to the longer-term strategy) and operational (designed to deal with shorter-term or day-to-day issues) elements. Where possible, as much effort should be made to make the reward approach people-centred and customised (CIPD 2016).

Excelling Through Culture and a Positive Working Environment

It has been argued that nursing leadership is an important contributor to retention and that leadership styles are a major factor in a nurse's decision to stay with an organisation (Acree 2006). The link with talent management in this respect is explicit. But there are other implications with respect to culture and environment. The largest comprehensive analysis of academic surgeons in the USA found that satisfaction with the working environment, collegiality and collaboration, and relationships with managers and supervisors were amongst the most predictive elements of whether surgeons remained with their organisations (Wai et al. 2014). The positive working environment and the culture of the organisation are powerful elements in the retention process. For new nurses, both job satisfaction and retention were related to perceptions of the work environment (Spence Laschinger et al. 2016), and research conducted amongst nursing staff in Taiwan concluded that to build a high level of organisational commitment, 'developing trust among nurses and increasing job satisfaction are more critical than compensating with monetary incentives alone' (Hsu et al. 2015: 567). A practice environment which includes trust as well as 'effective leadership, collegial support, and access to professional and career development opportunities' (Redknap et al. 2015: 263) is likely to create a feeling of positivity and excellence that can have an impact on employee retention.

Amongst the factors that can lead to the creation of excellence is a culture that values collegial physician–nurse relationships. These have twofold benefits, which are 'to promote the confidence of nurses to freely and effectively communicate with physicians in relation to patient care; and to promote a feeling of value and satisfaction in the care they provide' (Redknap et al. 2015: 267). Furthermore, 'the ability of nurses to influence decision making in their workplace is seen as an important element of this process and critical to the creation of positive practice environments' (Redknap et al. 2015: 268).

The complex nature of retention in health, which more than most areas of talent management is subject to significant contextual factors, means that there is no single 'solution' that will be relevant to all organisations.

The four areas above are intended to reflect some of the research and practice but will need to be adapted accordingly. The following summarises the points made in the narrative.

Conclusions and Implications for Practice

The ability of an organisation in the health sector to retain talented healthcare professionals has implications for the delivery of operational health service at the point of care and the strategic direction of the organisation. Retention is therefore an important part of the talent management process. However, the strategies that are adopted by organisations will be heavily influenced by the nature of the external environment in which they operate and the prevailing culture of the organisation. Nevertheless, it is possible to draw out some insights from the research that may be used to support the development of a retention strategy:

- Retention is a critical part of the overall talent management process and if it is included as such will contribute to a holistic, comprehensive approach.
- The factors that influence retention will vary from organisation to organisation and region to region. There will be shades of emphasis about reward, the level of training and development, and career opportunities. There is likely to be some consistency in creating meaning at work, which has more applicability in health than probably any other sector, and the provision of a positive working environment.
- Meaning at work arises when there is scope and time to provide compassion and care in health sector employee–patient relationships. Research shows that where this is present there is increased satisfaction and hence the possibility of greater retention.
- Providing career and development opportunities is a critical activity if talent is to be retained. The scale of these includes not only those in leadership or managerial positions but those in the whole workforce; the scope of these includes activities along the whole of the employee life cycle from training during the induction or onboarding phase,

coaching and mentoring at key points, and training or development programmes for knowledge and skills.
- The third element is about reward not only in its absolute sense of pay scales but in perceived fairness and satisfaction. Retention strategy includes both facets.
- Finally, the creation of a positive working environment spanning relationships with colleagues, line managers and the leaders of the organisation and a culture of openness and fairness are regarded as important contributors to whether health sector workers remain with or leave the organisation.

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12

The Role of the Board, the Executive Team, Line Managers and HR Professionals in Talent Management

Executives and Talent—A Symbiotic Relationship

There is a symbiotic relationship between those who lead and manage health sector organisations, those responsible for talent management and those identified as 'talent'. The board and executives accountable for strategy, stewardship and policy inform the direction of and allocation of resources to talent strategy; managers ensure that the processes of talent management are implemented effectively; human resource (HR) and talent professionals prepare the case for investment in talent, deliver consistency of approach across the organisation and monitor the outcomes; and talented people reciprocate through excellence in performance. This interdependence is most beneficial when all parties involved understand, engage and proactively manage the talent process (Alfes et al. 2013). Clarity of roles and responsibilities will be important in this regard.

The four groups of organisational decision makers critical to this process are therefore the board of directors or board of governors; the executives, executive committee or senior management team; line managers; and 'HR', organisational development ('OD') or 'talent' professionals,

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depending on the language and structure of the people management and development area.

In the first two, the board will be asked to approve talent strategy as part of the overall strategy setting process and the executive team then will be tasked with ensuring that it is delivered effectively and the value outcomes secured. Since chief executive officers and senior management teams dominate the organisation strategy (Choo et al. 2010; Lo and Fu 2016: 2182), their interactions on talent will have a direct impact on organisational performance, and active involvement is particularly important because of the value of HR, which could be two thirds or more of a health service organisation's budget (Spaulding et al. 2010: 1).

Hence, board-level involvement in talent management is critical to whichever definition of talent is chosen. However, from Sparrow and Makram's perspective (2015), where talent management is a resource-based value creation hypothesis, boards will have an interest in the talent management process and outcomes based not only on the impact on individuals (such as the development of successors) but on the impact on the organisation as a whole; that is a longer-term strategic perspective. However, this is a challenge because 'when boards make important strategic decisions, they rarely consider the overall workforce and talent management issues that these decisions imply' (Conger and Lawler 2015: 28), necessitating that HR and talent professionals develop a boardroom presence and use this to demonstrate, through the use of value-based metrics, overall benefits. Demonstrating a clear organisational need will be essential to talent management success (Pruis 2011). This means aligning talent management to the achievement of strategic goals and objectives.

The third group of influencers in the organisation are line managers (i.e., those who have responsibility for managing the workforce but are not in the senior management team) (Gooderham et al. 2015). Since managers are a vital resource for healthcare organisations (Belasen and Belasen 2016), their role in the implementation of talent management will be of particular importance because developing the capacity and capability of staff links to patient outcomes (Hutchinson and Purcell 2010). Their role will be not only to deliver on specific talent management initiatives but also to create a working environment that is reward-

ing, gives opportunity for full participation in the operation of the unit but—most importantly to the subject of talent management—gives team members the ability to fulfil their potential as part of a positive psychological contract (Armstrong 2003). Mentoring of the team as part of the talent management process will be aimed at improving patient care (Norman and Roche 2015). Line managers are instrumental in this.

Fourthly, the role of HR and talent professionals will embrace several areas of the employee life cycle, such as workforce planning or reward, but there is a point of view that 'those who approach their work as agile talent strategists are the most successful' (Gochman and Storfer 2014: 26). There is some way to go to achieve this since 'HR has not progressed significantly in terms of its strategic role in corporations because of the variety, and sometimes competing expectations of the roles played by the HR professional within their social system … potentially generate problems for HR professionals that undermine strategic decision-making inclusion' (Sheehan et al. 2016: 353). The conclusion is that as well as delivering day-to-day operational aspects of talent management, HR has a role in its strategic development. In the USA, research undertaken by the American Public Human Services Association led to the development of a framework by which HR professionals could make a full contribution to the achievement of health sector organisation strategy. The framework included executing the HR administrative functions, influencing culture, influencing direction and—most importantly in the context of this chapter—developing talent 'by creating employee development and training opportunities for increased organizational performance as well as opportunities for leadership and promotional experiences' (Light 2016: 20). Such an emphasis on HR management resonates both nationally (see inter alia Pallikadavath et al. 2013; Correia et al. 2015; Furlanetto et al. 2015; Santric Milicevic et al. 2015) and organisationally (Kumar et al. 2010; Baluch et al. 2013; Platonova and Hernandez 2013; Jończyk 2015), though the outputs can be variable (Cogin et al. 2016).

Figure 12.1 shows the areas of responsibility for each of the key organisational functions.

The symbiosis means that talent management will be most effective in healthcare organisations when there is clarity of roles and responsibilities between the board, executives, managers and HR professionals and

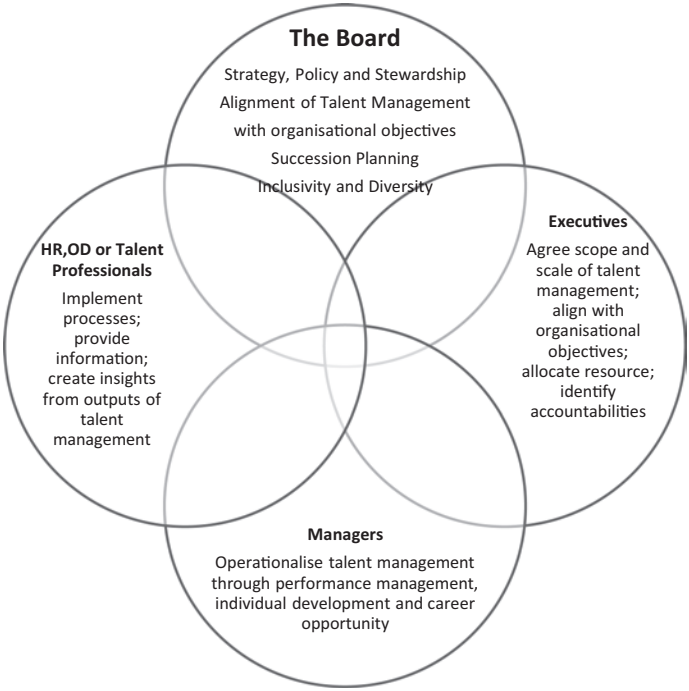

Fig. 12.1 The symbiotic relationship between organisational managers and talent

this is backed up by talent management processes and defined outcomes aligned to both the organisation's strategy and individual development (see inter alia Lewis and Heckman 2006; Ingram and Glod 2016; Gallardo-Gallardo et al. 2015; Sparrow and Makram 2015). This applies to whichever talent definition is chosen and to the methodologies of talent management that are executed.

In this model, the board has an oversight role, representing the stakeholders to ensure that they receive the best return for their investment, whilst executives, managers and HR professionals are responsible for its implementation. Dealing with areas of overlap between the various groups will play a key part in the effectiveness of how talent management is delivered. A more detailed description of the roles and responsibilities of each area is included below.

Sustaining and Enhancing Integrity—The Role of the Board

The growing complexity of the healthcare environment has led to a focus on governance structures and practices. Hence, the role of the board involves sustaining and enhancing the integrity of the health organisation as an institution and being effective in delivering high-quality health care. This is becoming more important because of both market and regulatory forces which are forcing boards to take on higher levels of governance accountability (Curran and Totten 2010; Millar et al. 2015; Prybil et al. 2014). As health sector organisations come under increasing scrutiny to improve performance in terms of both efficiency (finance and operations) and quality and patient outcomes, governance is broadening its orientation from control to performance in terms of clinical outcomes and the resulting governance mechanisms will have a direct effect on these outcomes (Bai 2013), where higher board involvement, participation and visibility can be positively related to improved organisational performance and the lack of participation can be associated with board failures (Langabeer and Galeener 2008). The cultural context of the board's make-up and attributes (Jaskyte 2015) will influence both the mission and the level of commitment to resourcing specific areas (such as talent management) to meet the objectives in fulfilment of the mission.

Governance boards have multiple roles, including to establish policies, approve or make strategic decisions and to oversee activity within the organisation to ensure positive values and a positive culture of safety and to create organisational value through performance, conformance and a responsible approach (Brandão et al. 2013; Christofides and Sharp 2015). Corporate governance includes shareholder financial interests; in public organisations, the state's interests; and in third-sector organisations, a combination of public or more diverse stakeholders' interests (Barnett 2014; Collum et al. 2014; Sheaff et al. 2015; Rotar et al. 2016). Effective corporate governance in health leads to efficient and effective administration. In the Czech Republic, for example, 'if the balance of power between the executive and administrative authority is implemented

properly, together with clearly defined and delegated competences, then positive results can follow' (Pirozek et al. 2015: 1093); and in Ghana, hospitals with a governing board performed better than those without a governing board (Abor et al. 2008). The importance of a long-term perspective, a diversity of opinions and conceptual thinking for board members was deemed important in both Canada (Hansen 2013) and in Norway, where hospital boards 'have to act in contexts of ambiguity and uncertainty. In such situations, a wide decision space will face the boards with problems related to emotions and opportunism. Thus, the principals in the context of public sector hospitals have to balance among strong political influence, hierarchical modes of governance and discretion given to the boards' (Pettersen et al. 2012: 269). In the behavioural theory of the firm, decision makers set targets or aspiration levels for desirable performance and offer solutions to fluctuations in performance (Desai 2016) over which the board of directors will have stewardship. This model can apply to the health sector as in any other, though the complex mix of private, public and hybrid organisations adds an extra dimension to the theory.

Board-level involvement is important in the positioning of talent management. Overall responsibilities are those covering not only strategy, policy and stewardship at the organisational level but also at the level of the talent. This will be to ensure that there is alignment of talent management with organisational objectives, that a credible succession plan is in place and that inclusivity and diversity are enshrined in leadership, management and whole workforce development. In the USA, it was noted that board work has become more and more centred on talent management 'since not having the right talent in place is one of the most significant risks an organization can face' (Sartain 2015: 18), whilst the boards of Indian companies, regarded less as independent overseers and more as partners to management with broader roles beyond traditional agency-theory-driven fiduciary responsibilities (Veliyath et al. 2016), still identified talent as an important part of their sphere of influence. Amongst the issues identified at the board level were the overall business or organisational strategy and their impact on talent strategy, the longer-term implications of talent demand and supply on the organisation's ability to deliver its objectives, and succession management for the most senior

levels (National Association of Corporate Directors [NACD] 2016). But, as noted earlier, the evidence of the emerging role of HR in the boardroom and the interest of the board in HR issues of which talent management is a specific example is mixed. Conger and Lawler found that 'boards focus narrowly on only two human capital topics: executive compensation and succession. When boards make important strategic decisions, they rarely consider the overall workforce and talent management issues that these decisions imply' (Conger and Lawler 2015: 28). One of the reasons for this is that HR has not sufficiently made the case that talent is an essential issue in risk considerations. This is problematic because areas that impact on the ability to retain, attract, develop, or reward talent to support strategic business goals will have serious effects on its performance at several levels (Chen 2015: 38). There is an onus on HR, OD and talent professionals to ensure that their board-level interaction is strategic and value-adding (Martin et al. 2016: 31). The orchestration of HR can facilitate the execution of responsive integrative strategy-making processes (Juul Andersen and Minbaeva 2013) which can contribute greatly to the success of talent management.

Providing Oversight and Allocating Resource—The Role of Executives

If the board have responsibility for strategy, policy and stewardship (with executive involvement), then executives in the health sector have the responsibility for translating the strategy into sustainable implementation. They will achieve this through clarifying objectives and unit and individual accountability and ensuring that sufficient resources are allocated for the achievement of the strategy. In addition, they will want to ensure that they have the right people in the right place with the right skills to deliver the strategy and this reinforces their involvement in talent and talent management. The executive roles in talent management consist of acting as champion of the necessity of talent, providing a vision of how the health organisation will benefit from maximising the contribution of its talent (however defined), ensuring that there is pluralism in the approach and that individuals as well as the organisation as a whole

are given the opportunity to benefit, ensuring that sufficient resources are allocated for the delivery of talent management, mediating between areas of resource or operational conflict, and ensuring that the board are aware of progress and results.

Executive leadership with strong HR management has a positive effect on influencing employee perceptions and interpretations (Pereira and Gomes 2012: 4301). A combination between the two will facilitate the alignment of the workforce to the organisation's strategic outcomes (Soo et al. 2010). This is especially apposite in the health sector because health units are complex organisations and executive decisions can have significant implications for patient care and safety, innovativeness in responding to health sector challenges and financial well-being (Alam et al. 2016; Hawkins 2016). It has been shown that if health executives can articulate a vision which will lead to clarity about role and purpose (for example, at the hospital unit level), this will have an impact on financial and other performance indicators (Gulati et al. 2016). Effective leadership in hospitals is recognised as critical to organisational performance increasingly linked to the leadership practices of hospital managers (Kim and Thompson 2012: 113). This is accentuated because as the healthcare system evolves towards more integrated care 'the systems are more than the traditional hospital-centric structures, as acute care becomes just one component in a larger system that includes ambulatory care, acute and post-acute care, chronic disease, end-of-life management, and all structures in between' (Hafeman 2015: 69).

The roles of executives in talent management are both strategic and operational, including (in the USA) engaging frontline staff in identifying, designing, testing and implementing new processes and methods (Needleman et al. 2016). Executives, whether as part of an executive committee or senior management team, will agree on the scope and scale of talent management, ensuring that these are aligned to organisational objectives; they will then be in a better position to decide upon the level and allocation of resources to deliver talent management and identify who is accountable for subsequent deliverables. Critically to talent management in a clinical context, they also have the objective to scale up leadership skills and decision-making authority (Opollo et al. 2014).

Partners in Talent Management—The Role of the Line Manager

Line managers have the responsibility for delivering a wide range of HR practices and if they do so successfully will also have a positive effect on employee outlook (Gilbert et al. 2011; Armstrong-Stassen et al. 2014). Talent management is a part of this process, and line managers are important partners in helping employees to take up developmental opportunities in 'a tripartite partnership between the HR function, line managers and employees within organizations … much of the individual employee career planning, management and decision-making is increasingly played out between the employee and his or her line manager' (Crawshaw and Game 2015). The value is that development activity has a positive effect on motivation, employee commitment and contribution and, through training and development, employee self-confidence (Claussen et al. 2014; Hashemy et al. 2016). In effect, line managers operationalise talent management through a variety of HR processes, including performance management, and support for individual development and career opportunity.

The ability to do so is a significant challenge for those managing in the health sector (King's Fund 2011) resulting from the necessity of combining day-to-day pressures caused by rising patient and public expectations with financial management and overall resourcing (National Institute of Healthcare Research [NIHR] 2013). This is particularly challenging when clinical staff make the transition to administrative or managerial roles, a growing occurrence as demonstrated by research in Organisation for Economic Co-operation and Development countries (Rotar et al. 2016), thereby having to combine two professional elements into the single role. Hospital management encompasses hospital planning and operational activities, including development and implementation of organisational strategies to ensure adequate numbers and quality of trained HR and effective financial management, disaster management, health management information system utilisation, support services, biomedical engineering, transport and waste management (Rabbani et al. 2015). Nevertheless, the role of the line manager

in health is mostly about supervision and people management (Hales 2005). Because there are different forms of medical management experienced over time, there is the possibility of the engagement of a large proportion of professionals willing to take formal management roles (Lega and Sartirana 2016).

In this context, line management embraces a wide variety of roles and definitions. In the British National Health Service (NHS), for example, around 5% of the workforce are identified as managers in 78 categories (King's Fund 2010). In addition, there are many without the designation of line manager who undertake management activity, including clinical professionals with line management in addition to professional responsibilities (NIHR 2013), also a feature in Portugal, where the growth of 'hybrid managers' who combine professional and managerial knowledge, a combination that has been shown to enhance clinical and management outcomes (Correia and Denis 2016), has been observed.

There is evidence that that effective line management and supervision in the health sector increase both job satisfaction and worker motivation (Bailey et al. 2015). In the USA (Marx 2014) and Korea (Kim and Windsor 2015), the quality of interactions between managers and their teams and managerial and organisational relations were deemed important to overall performance. These factors also have a link to employee retention. It follows that effective line management can have an impact on whether talented people join, or are engaged and stay with, the organisation. The role of line managers as important contributors to talent management starts at the recruitment stage and continues through the employment life cycle. In this respect, the people management responsibilities of line managers include operations issues such as setting performance objectives, setting the tone and culture of the working environment to facilitate engagement and motivation and finally as a talent manager by identifying and encouraging potential and facilitating career growth and opportunity.

It is possible to summarise the role of the line manager in talent management as outlined in Fig. 12.2.

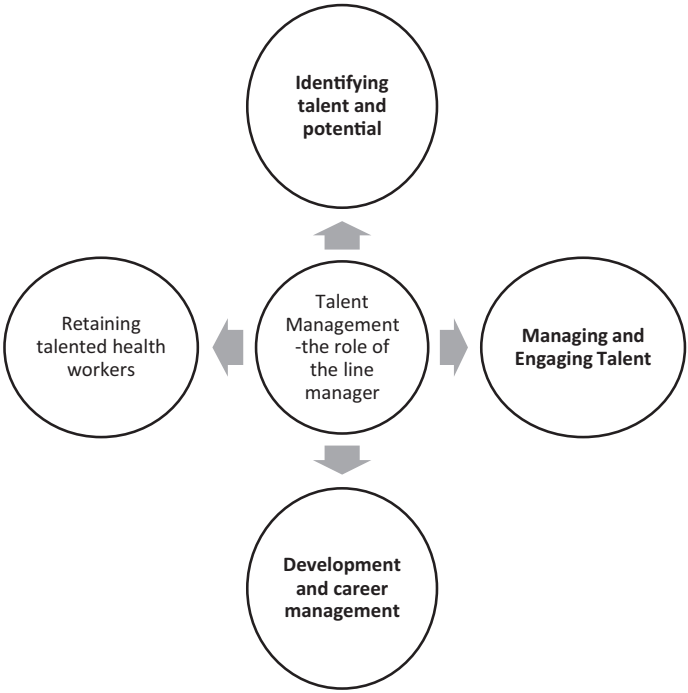

Fig. 12.2 The line manager's role in talent management. Source: After NHS Leadership Academy (2015) Talent Management: the role of the line manager

Identifying talent and potential (or acting as 'talent spotter' (Hirsh 2015)) will involve those members of the team who have the potential to take on additional roles or responsibilities beyond the current performance management goals and targets. These can be in relation to any leadership or competency outlines within the organisation. The pluralistic nature of talent management as outlined in earlier chapters means that the manager has a role to play in identifying those who can move upwards in the organisation in classic developmental style but also facilitating the maximisation of talent and potential in the current role. Fernandez-Araoz (2014) has defined those with talent as those with the right motivation and a commitment to excel, those with curiosity and insight (able to make sense of information) and those with determination.

Strategic Positioners and Credible Activists—HR, OD or Talent Professionals

Given the criticality of healthcare professionals in delivering high-quality patient care and the fact that, in many organisations, people costs can constitute from 65% to 80% of the operating budget, 'it is imperative for health care organizations to manage effectively their human resources' (Fottler et al. 2010: ix). The importance of the role of HR, OD or talent professionals in this environment has grown because of the recognition of the impact of good HR practice, and whilst national contexts will shape the nature of HR involvement in healthcare organisations, 'the one constant across different national settings is the critical importance of human resources both in terms of their ability to impact patient outcomes and hospital costs. Impacting on this situation is a world-wide shortage of nurses, documented poor doctor and nurse commitment and job satisfaction and continued challenges of quality in patient care and patient safety' (Bartram and Dowling 2013: 3031). Indeed, achieving coherence between health policies and HR strategy, as shown in studies of Vietnam, China and India, can be the difference between success and failure in the achievement of health outcomes (Martineau et al. 2015).

In some health sector organisations, the responsibility for talent management will reside within the HR function; in others, it will be part of an associated but separate HR development (HRD) function, and in some organisations there will be a separate 'talent' professional with responsibility to deliver talent management in conjunction with HR management (HRM) and HRD colleagues across the organisation. The dynamics between HRM, HRD and talent are therefore important. Studies of HR across the health sector have concluded that it 'not only is a single-functional job, but also is a multi-functional process involved the functional cooperation of all subsystems working within the health system' (Hassani et al. 2013: 56), that it 'aims to improve the performance of the employee and also to promote the competitiveness and the business performance' (Frixou and Charalambous 2016: 358), and that it is involved in change management which plays a vital role in ensuring

quality and goal achievement; and the people aspect of change is a key driver for successful change management planning (Al-Moosa and Sharts-Hopko 2016). Research has shown that where the function is responsive and innovative (Srinivasan and Chandwani 2014), it can be an instrumental factor in the delivery of change and transformation.

It is clear from these descriptions that the role of HR and in particular that of talent manager will be interpreted in different ways, in different organisations in different geographies. In essence, though, it will be the responsibility of those with talent management accountability within the HR function to make sure that the processes of talent management are implemented to their maximum effect, that information is provided on the progress made in the talent strategy but critically providing information about the impact of talent management on the ability of the organisation to achieve its objectives. It is a differentiator on the part of talent professionals that they have knowledge to provide insights about the impact of talent management (such as return on investment on talent) rather than data such as number of people trained, number of programmes run and so on (although this remains important from a processual view).

Marchington's (2015) eloquent summary of the differing critiques of the role of the HR function concluded that in its 'desire to look up the organisation, it has become a servant to short-term performance goals and the mantra of shareholder value rather than the development of longer-term sustainable contributions based on shared values and fairness at work' (Marchington 2015: 177). But both will have to be embraced if success in talent management is to be achieved. On the one hand, talent management will need to demonstrate strategic significance within the organisation, which may come about when 'it has a substantial degree of involvement in the development of the … strategy; and … whether line managers are involved in its evaluation' (Gooderham et al. 2015: 715); on the other, it will require HR professionals to deliver on their 'champion' role if whole workforce development is to be achieved and talent management delivers to its full pluralistic objectives. In both cases, a close relationship between HR professionals and executives or line managers will be necessary. Indeed, it may be the difference between success or failure of talent management.

Interaction and Collaboration Are Key to Success

Whilst crafting a talent strategy can be undertaken objectively through data analysis and strategic planning processes, delivering talent management effectively will depend on the nature of the interactions and collaborations between the board, executives, managers and HR or talent professionals. Resolving issues in the areas of overlap shown in Figure 20 will determine success as much as clarity within the circle of responsibility.

The belief that more effective HRM practices could improve performance in terms of employee satisfaction, patient outcomes, cost-effectiveness and staff retention is a driving force for the increasing attention being given to the subject in the health sector (O'Donnell et al. 2012). As shown in previous chapters, talent management has an impact on and can be overlaid on several HRM practices. However, there is sufficient evidence to demonstrate that the impact is less where practices are divergent and where these practices do not have the involvement of executives and managers from the board through all organisational levels. Responsibility for talent management is increasingly becoming the responsibility of frontline executives and 'many aspects of talent management are best handled by day-to-day managers' (Cappelli 2013: 25). Interaction and collaboration are key to successful talent management. Research into the effectiveness of nursing line managers on a range of HR issues from workplace learning to career management (Saidi et al. 2014; Kantanen et al. 2015) bears testament to the necessity of close collaboration between those in line roles and those in HR, OD and talent roles as contributors to the effectiveness of talent management. This reinforces Alfes et al.'s (2013) conclusion that 'line managers play an important role in creating and maintaining a positive environment in which employees are willing to engage and perform. This emphasises the importance of a symbiotic relationship between HRM professionals and line managers. Collaboration between both parties will enable the effective implementation of HRM practices, which are positively perceived by employees and encourage them to reciprocate by enacting desired behaviours. Our study demonstrates that it is through effective partnership that

HRM practitioners and line managers are able to elicit positive responses from their workforce' (Alfes et al. 2013: 852–853). Such a conclusion is important to those responsible for implementing talent management in the health sector. There are several aspects to this.

In the first place, there is the necessity to ensure a strategic alignment that will come about only by collaboration and joined-up thinking. Questions to be asked to ensure that the relationship is executed effectively include the following: does the strategy 'articulate the performance expectations and core competencies required to execute it successfully? Is the … strategy used to drive how we define the leadership capabilities, functional and operational expertise, and specialized knowledge targeted by the talent strategy? Are the significant human capital risks reduced to an acceptable level by the talent strategy?' (NACD 2016: 8). The answers to these questions will be best achieved by interaction between the board and executives to ensure consistency in the strategy and what is expected at the organisational level, between executives and managers to ensure that corporate or higher-level objectives are cascaded into performance management, between executives and HR or talent professionals to ensure that the processes of talent management are aligned with and have the objective of delivering organisational outcomes, and between line managers and HR or talent professionals to ensure that the appropriate level of support is allocated. All of the players will have the objective of diversity and inclusivity in talent management from attracting and recruiting talent through to assessment, selection and promotion to talent development whether this is leadership, management or whole workforce.

In the second, there is the necessity to ensure what might be called management alignment, which will be concerned with the belief in and active engagement with talent management on the part of those responsible for day-to-day operations in health sector units.

Finally, there is professional alignment, which means that talent management activities are designed with the needs of both the organisation and individual employees in mind and that they reflect the priorities of the organisation and are accessible by the whole workforce. In this respect, it has been argued that HR and talent professionals could occupy a middle seat which is the role between the strategy and executing the

functional initiative and in health this can be effective collaboration between HR or talent professionals and management or professional functions (Creelman 2015).

Conclusion and Implications for Practice

The diversity of organisational types in the health sector, together with the different stages of evolution in talent and talent management as outlined in earlier chapters, means that there will be different interpretations of this approach. In archetypal governance structures there will be a dominant logic of, for example, shareholder value; whilst hybrid organisations might be characterised by 'enlightened shareholder value or employee-ownership present different challenges for both HR and talent practice' (Martin et al. 2016). But not all health organisations have formal board governance structures, nor do they have role clarity between say human resources and talent management, nor the luxury of reflecting on strategy or stewardship, instead driven by serious day-to-day people issues. However, the principle of best fit adopted in other areas can apply. The necessity of ensuring that any talent management activity is aligned to what the health unit is trying to achieve and has the backing of senior management; the 'buy in' of line managers and the engagement of the whole workforce are also relevant whatever the size or scale of the unit. And most importantly ensuring that HR activity, of which talent management is an important component, creates value by making sure that the services offered inside the company are aligned to expectations outside the company' (Ulrich and Dulebohn 2015).

Analysis of the roles, responsibilities and accountabilities of the board, executives, managers and HR or talent professionals in health sector organisations shows the importance of alignment between the goals and intentions of all four groups.

- In the first place, there will be the need to ensure effective strategy, stewardship and policy. The board and executives are clearly important in this, but increasingly the HR or talent professional will have the role of strategic positioner (Ulrich et al. 2013), being involved in aligning

talent management with the overall goals and objectives of the organisation. There are two aspects to this. Firstly, the HR or talent professional reflects the objectives of the organisation by aligning talent strategy accordingly. But there is also a proactive role to play in influencing the strategy to reflect talent reality whether this is one of shortage or opportunity.

- In the second place, it is important for HR and talent professionals to be seen as credible activists (Ulrich et al. 2013) by building up trust and respect with the organisations executives and managers, delivering effectively and from this strong position having input into the direction of strategy. This means acting as trusted advisor to the board, executives and managers with respect to talent management. It requires a demonstration of knowledge of the organisation beyond HR or talent and a willingness to understand general management decisions as well as those pertaining to talent or talent management.
- The third is that of capability builder (Ulrich et al. 2013), ensuring that talent management is developed to achieve both individual and organisational objectives, thereby ensuring that the overall strength of the organisation is enhanced by them. The overall success of the health organisation will depend on its ability to respond to external forces (in private sector health, this might be competition; in the public sector, it might be political influence) through the effective deployment of talented people to meet the specific environmental circumstances in which the organisation finds itself. This will require the HR or talent professional to act as capability builder rather than reactive skill shortage filler.
- Finally, the HR or talent professional will act as innovator and integrator, providing insight into good practice (geared to best fit for their organisation), providing the know-how to ensure that talent management is successfully aligned to strategy and integrated into management practice across the organisation, and (where possible) providing innovative solutions to the organisation's needs.

The strength and relevance of these conclusions will depend on the status of talent management in the health organisation. Nevertheless, there is a case for arguing that the principles can be applied to most.

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13

Twenty Important Conclusions About Talent Management in the Health Sector

The Changing Landscape of Talent in Health

A global health workforce of over 40 million people and global spending on healthcare worldwide of US$7.2 trillion have raised the profile of health workforce management and, in particular, of talent and talent management. On the assumption that there can be no health service without a health workforce, organisations seek to provide the highest attainable standards of health by maximising the contribution of talented clinical, managerial, operational and technical professionals.

At a supranational level, such as that addressed by the World Health Organization, talent management has, at its core, the improvement of health, social and economic outcomes by facilitating the availability of a skilled health workforce able to deal with powerful external forces but also a transformation in the way in which healthcare is delivered. These stretching goals are compounded by an additional complexity in that the meaning of health has expanded to include those elements which give complete physical, social and mental well-being and which satisfy the demands of a life commensurate with age, culture and personal responsibility.

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Health services now take place in a broad socio-politico-economic framework, and providing talented people to run and provide these services is a strategic issue impacted by not only short-term phenomena but also the demand for longer-term, sustainable outcomes. However, factors such as the increase in the risk of non-communicable disease as well as significant social and demographic change (for example, the ageing population) often mean that the demand for healthcare outstrips the supply of those who can provide it. This imbalance can result in tensions as countries and organisations compete to attract and retain talented health workers. Global policy organisations are attempting to rectify imbalance and maldistribution by calling for interconnected efforts to produce larger numbers of health workers and innovative approaches to workforce planning and management. Their sustainable goals can be achieved only if significant, strategic investments are made in the global health workforce as well as a substantial movement towards greater health workforce planning, effective education, and professional human resource (HR) approaches to deployment, retention, management and reward. Hence, the challenge is to ensure that the right quantity, quality and skill mix to match current and future needs and expectations.

The phenomenon of talent shortages in healthcare is global in its reach, has multiple root causes and will require sophisticated national and organisational talent strategies to deal with complex scenarios. However, the main focus of this book has been at the organisational level, characterised by individual or groups of health units. In these organisations, talent management is the activity associated with attraction, development, management and retention to meet their own organisational objectives. Macro trends will have an impact but there are other dynamics such as the corporatisation of health services, workforce mobility, multi-generational workforces and more diverse, empowered employees.

There is no single magic formula that will provide the answer to the challenges facing health sector organisations as they try to balance demand for health services against the supply of people who can provide them, but effective talent management can be part of the solution.

Reviewing research and evidence from the experiences of health sector organisations around the world has led to conclusions that may be applicable to those seeking to develop a talent strategy. However, the principle

of best fit, based on the ambiguity about what is meant by talent and talent management, means that organisations will seek options that are most suitable to their specific context.

The most important conclusions are shown below.

Twenty Important Conclusions About Talent Management in the Health Sector

1. Effective HR management, of which talent management is a critical component, will contribute to the creation of an efficient and functioning healthcare system, which in turn can go beyond being a 'consumption sector' and can have positive returns on the economy as a whole and can be viewed as an investment with potential to contribute to broader poverty-reduction strategies.
2. But to do so means having the right people in the right place with the right skills at the right time. This will require both effective health workforce planning and a deliberate and systematic approach to talent management. To achieve this will require a clear, organisation-wide definition of talent and an understanding of the activities that will take place within the boundaries of talent management. These are essential to the efficient allocation of resources and the optimum level of return on these investments.
3. There are factors that are unique to health that accentuate the focus on people management in general and talent management in particular. These include the imbalance between supply of and demand for talent around the globe, which is more prevalent in health than in other sectors; the intensity of public scrutiny of the quality of the outputs of talent in the health sector, whether these be clinical or managerial, which places the spotlight on both organisations and individuals; and finally the levels of training and continuing education, the development of professional competence and specific development can be the difference between life and death, with the added expectation that talented people in health are competent in dealing with such gravity.
4. Talent in health is driven largely by phenomena ranging from the need for transformational leadership to deal with the wholesale

changes and demands that are a feature of the contemporary health environment, to specific workforce 'segment' challenges such as nursing shortages, to a specific event (pandemic) or change (technology). A definition of talent has to take account of the various external forces and internal dynamics in each organisation.

5. Developing a talent strategy for a health sector organisation therefore has more moving parts than for most other organisations. However, if taking a strategic approach to talent is desired, then a definition will need to allow for different contexts, will be based on a pluralistic approach to talent and would provide the scope to adapt. In this position, a realist view of talent definition leading to 'what works, for whom, in what contexts, to what extent, how and why' might be:

   Talent in the health sector refers to those people whose professional expertise delivers positive patient or societal outcomes and whose operational competence and performance create stakeholder value for the organisation.

6. The definition of talent management is directly bound by that of talent and is proposed as:

   Talent management in the health sector refers to the attraction, recruitment, management, development and retention of those whose professional expertise or operational competence contribute to positive patient or societal outcomes and the creation of stakeholder value.

7. These definitions allow for organisations in the health sector to adopt a range of approaches to talent management which align broadly into common HR practices or wider succession planning or a focus on strategic, core jobs that are critical to creating competitive advantage. The responses to workforce challenges were mostly phenomenon- and occasionally strategy-driven. Whilst there are a range of exemplary talent practices from which to draw, health sector organisations tend towards a phenomenon-driven approach to talent management, one that means best fit for their specific sets of circumstances or context. It is from their chosen position that they can then select

strategic options for the direction and resourcing of talent strategy. In order to facilitate the discussion about the direction in which talent management should go in any specific organisation, the starting position on a talent management evolution matrix will be identified. This is based on a position along two axes: the level of conceptual acceptance in the organisation and the ability to make talent management work through practical implementation.

8. A talent strategy will ensure that talent management is either aligned to or fully integrated with the overall organisational strategy, and it will give organisations both direction and resource allocation indicators. The talent strategy will be the activity designed to move an organisation from one point on its evolution to another. The goals and objectives will be either aligned to those of the organisation or integrated into the fabric of decision making. A definition taking account of the unique requirements of the health sector may be put forward as:

   > Talent strategy in the health sector is that activity which determines the scope of talent and talent management, sets the long-term direction, and ensures resource allocation to and development of people identified as providing professional expertise or operational competence for the achievement of the organisation's goals.

9. A critical component of talent management will be the development of the organisation's leaders. In health, the complexity of leadership requires skills that transcend those 'normally' associated with the subject. Studies have identified over fifty competences for health leaders, including the ability to understand health issues and synthesise divergent viewpoints, as well as an understanding of reflective leadership, servant leadership, adaptive leadership and the application of emotional leadership. However, there is a case for extending the definition of leadership in health sector organisations on the basis of the argument that leadership is situational and non-hierarchical. Hence, leadership is not confined to executives and the boardroom. Increasingly, therefore, there is recognition that the concept of leadership in health means more than the most senior members of the organisation and other leadership positions would need to be

considered, to the level of point of care, if talent management were to be most effective.

10. Succession planning goes in tandem with leadership development and has been defined as a strategic process involving identification, development and evaluation to ensure leadership continuity within the organisation. For the most senior positions, identifying desired leadership competences was considered to be the foundation of succession from which to inform subsequent elements of talent management such as leadership development. Distinct elements have been identified in the succession process which include strategic planning, its translation into skills and competences to achieve strategic goals, key positions and the selection of suitable candidates to fill them. Once this part of the succession process has taken place, talent management tools such as mentoring and coaching or other developmental activities are introduced and the final element of evaluation is put in place. Succession planning also provides the basis for determining the optimum mix of internal and external recruitment and the consequent level of leadership or management development. At each level, leadership development and succession planning are inextricably linked. Talent management plays a critical part in defining the competences for succession (aligned to the organisation's objectives), the assessment processes in identifying which people would have the potential for succession roles, and developmental actions or programmes to address individual needs.
11. It was noted that if leadership was the only development that took place, then there could be a lost opportunity to maximise the talents of the majority of the workforce, which could also have a negative impact on engagement (because employees of or partners in the organisation may feel excluded by exclusivity). To deal with this, a more inclusive, pluralistic approach to talent and talent management is emerging. In this scenario, talent management at both the organisational and the individual level is recognised, the objective being to maximise the return on investment in talent and at the same time balance individual and organisational goals to the mutual benefit of all. The need to engage and develop a broader group of employees to ensure that strategic drive is underwritten by capability

at, for example, the point of care is important and is referred to as whole workforce development. As health workers around the world take on new roles, nurses performing tasks that were previously undertaken by doctors, for example, and community health workers and nursing assistants developing new skills, the concept of whole workforce development becomes critical to success. This may be defined in the following way:

> Whole workforce development concerns the learning, training and development resource and activity required to build a fit-for-purpose health workforce with the right competences needed to deal with the goals, objectives or priority issues in each organisation in each geography served by the health unit or group of units.

12. Three principles can guide leadership, management and whole workforce development. These are **applicability**, congruence between the training content and practitioner experience, to ensure that any development activity is relevant to the needs of both the individual and the organisation and can be shown as such; **accessibility** because if the worldwide shortage of healthcare workers is to be addressed, there needs to be accessibility for greater numbers of people to opportunities to learn, train and develop; this not only can provide valuable skills but also could address shortages of healthcare workers and improve retention rates; and **alignment**—with the overall direction and goals of the organisation.
13. An important aspect of talent management in the health sector is attraction and recruitment to meet numerical coverage and skill objectives. The effect of powerful forces on the attraction of talent to health sector organisations has been dramatic. Now recruitment is an extremely competitive, sophisticated, multi- dimensional process that involves the ethics of recruiting from developing regions, the reputation of the organisation, the organisational culture in which the role takes place, and a broader framework for employment.
14. One way in which organisations can increase their attractiveness during this process is to present an attractive employee value proposition which includes monetary reward, career and professional develop-

ment, organisational reputation, and recognition of individual values and beliefs. Such a proposition should be reflected in the employer brand.

15. To date, relatively free labour markets have seen unprecedented movement of skilled health workers as they respond to demand and career opportunity. However, there are pressures to limit such movements, based on net outflows of skilled health workers from low- to middle-income countries, and it is unclear whether such freedom will be as liberal in the future. Hence, there is pressure to engage and retain existing valuable talent and this is another part of the talent management process.
16. The ability to engage employees in the health sector is important because it has an impact on the quality of care, patient satisfaction, and safety. An engaged and committed workforce can contribute to improvements in clinical processes, health and financial outcomes. Sustainable healthcare organisations depend on successfully engaging healthcare professionals. In healthcare environments, employee engagement is a concept that concerns the whole organisation from point of care to the engagement of non-clinical, technical and ancillary employees. Employee engagement has a relationship with talent and talent management because the highest positive values of the correlations between HR practices and job satisfaction were training and development and selection. Opportunities for development were critical factors in engaging the healthcare workforce.
17. Retention is defined as the extent to which an employer is able to keep its employees in the organisation and can be expressed as the proportion of employees with a specified length of service as a percentage of overall workforce numbers. It is a key part of talent management through career development and progression, two of the key levers used by employers in building up their retention capability, and indirectly related through talent management activities in the areas of attraction, recruitment and engagement.
18. There is a symbiotic relationship between those who lead and manage organisations and those responsible for talent management. This might be explained as follows: the board and executives are account-

able for strategy, stewardship and policy and inform the allocation of resources to talent; line managers are responsible for implementing the processes of talent management effectively; HR and talent professionals ensure a consistency of approach across the organisation and monitor the outcomes of talent management initiatives; and finally talented people reciprocate through excellence in performance. This interdependence is most beneficial when all parties involved understand, engage and proactively manage the talent process.

19. The success of talent management can be measured in terms of the individual and organisational outcomes to which it contributes. These include those relating to patients, the effective use of resources in delivering health services, operating efficiency and improved employee engagement and retention. These can be identified in each organisation by a process of 'outside in' thinking in which the objectives form the basis of talent priorities and talent management activity is designed to achieve these.
20. Collaboration and coordination will be critical to the success of talent strategy and management in health sector organisations. This means collaboration between talent professionals, the board, executive team and managers and coordination with other HR management activity. Whilst crafting a talent strategy can be undertaken objectively using analytics, delivering talent management effectively will depend on interactions and collaborations.

The previous chapters have outlined the context within which talent management is taking place in the health sector, the characteristics of developing a successful talent strategy, and the implications for the organisation in converting this into practice.

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