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**THE ROLE AND EXPERIENCE OF WOMEN CHIEF
EXECUTIVES IN THE NATIONAL HEALTH SERVICE IN
ENGLAND: GENDERED STORIES OF LEADERSHIP IN
DIFFICULT TIMES**

BY

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A thesis submitted to

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ABSTRACT

This research sought to map and analyse the demography of the two main populations of chief executives in the National Health Service (NHS) in England, namely those in primary care trusts (PCTs) and NHS trusts. A national survey of chief executives was carried out in 2003 and repeated for follow up purposes in 2006. This revealed that the PCT chief executive population differed significantly from that of NHS trusts in relation to: gender; age; salary; and career history.

The second stage of research focused on the role and experience of women chief executives in the NHS. Narrative analysis of ten in-depth interviews with women chief executives revealed six dilemmas within their presentation of stories of 'crafted selves'. Original findings included: the role of the 'corporate husband' or partner; the importance of male sponsors; the dissonance between personal and organisational values; and evidence that women have chosen to adapt to (and not challenge) the prevailing culture and model of leadership in the NHS. The research reveals the extent of the strength and persistence of a masculinised model of organisational leadership in the NHS, a culture that forms the context to these gendered stories of leadership in difficult times.

DEDICATION

This thesis is dedicated to my father Derek Anthony Smith (1930-1987), whose principles, faith, dying and death inspired the interest in identity, self and feminism that underpin the journey and destination of this research.

ACKNOWLEDGEMENTS

I would like to express my thanks to Chris Ham and Peter Spurgeon for encouraging me to embark on this research, and to Edward Peck, Jackie Cumming and Margie Apa for generously allowing me the time to carry out the analysis and writing up of the study. My supervisors Edward Peck and Tim Freeman have given insightful, challenging and timely advice throughout the period of study, and it has been an absolute pleasure to work with them, benefit from their expertise, and test out emerging findings and ideas with them.

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Most of all however, my thanks go to Tony, Richard and Kathryn, whose willingness to be without their wife and mother during countless weekends and evenings has enabled this thesis to be completed during our time spent on sabbatical in New Zealand. I know only too well how important the love, support and sacrifices of a 'corporate husband' are in enabling a woman to pursue her work and career goals.

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LIST OF ABBREVIATIONS

CE	Chief executive
CEO	Chief executive officer
DGM	District general manager
FHSA	Family health services authority
FPC	Family practitioner committee
FPS	Family practitioner services
GMTS	General Management Training Scheme
GP	General practitioner
HA	Health authority
MTS	Management Training Scheme
NATS	National Administrative Training Scheme
NHS	National Health Service
NHS FT	National Health Service foundation trust
NHST	National Health Service trust
PCG	Primary care group
PCT	Primary care trust
RGM	Regional general manager
RHA	Regional health authority
SHA	Strategic health authority
TPP	Total purchasing project
UGM	Unit general manager

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CHAPTER 1

INTRODUCTION

‘What we call the beginning is often the end
And to make an end is to make a beginning.
The end is where we start from. [...]

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.’

TS Eliot (1944)

The end is where we start from

The title of this thesis points to the end of the research – the revelation of a set of gendered stories of leadership in difficult times. This research represents a journey of almost a decade, a personal exploration of self and selves, those I choose to present within my own story of career, and those I now realise I chose (and choose) not to pursue or present.

The study started out in 1999 as research into the chief executives of primary care organisations in the English National Health Service (NHS), a topic which attracted my attention when carrying out work evaluating the development and implementation of primary care groups (PCGs) and primary care trusts (PCTs) in the NHS. The puzzle that was in my mind was concerned with what I perceived as ‘difference’ among the population of managers in the primary care organisations I was researching. This ‘difference’ was articulated in my research outline as being something to do with gender (there appeared to be more women leading these new primary care organisations compared with my experience of senior management in

the NHS), age (they seemed to be younger), experience (they seemed often to be new to a chief executive post), and background (they seemed more likely not to have been a hospital manager, a national management trainee, or to have ‘come up through the ranks’ of NHS management). This interest in the population of chief executives of primary care groups and trusts led me to set out the following initial questions for the research (Smith, 2000):

Box 1.1: Research questions in April 2000

- Who are the PCG chief executives? Where do they come from?
- What do the PCG chief executives do? What support do they have?
- What are the motivations and aspirations of the PCG chief executives?
- What becomes of the PCG chief executives over time?
- What lessons can be drawn for NHS policy and management, based on the experience of the development of this new group of general managers?

It is evident from these questions that, at this stage, I was regarding the study as a piece of work in the spirit of policy evaluation, some form of assessment of how NHS policy on the development of primary care was being implemented, and in particular what this meant in terms of the emergence of a new category of senior managers. I was not consciously aware of the personal journey that I was embarking upon and of where I was going to take the research (or it was going to take me), nor did I stop to reflect on what it was that was perhaps influencing my interest in this topic.

Before going on to describe more of the exploration upon which I was unwittingly embarked, I am going to tell something of my own ‘story of career’ so that something of myself is brought into the account of the research, and made present as important context to the reflexive nature of the study, its analysis and presentation.

My story

My first degree was in French Language and Literature at the University of Birmingham, and in my finals papers, I focused almost exclusively on study of 20th century authors. In particular, I was drawn to the work of Simone de Beauvoir, Samuel Beckett, Ionesco, Camus, Gide, Colette, and Proust. I took my finals at a time of significant personal stress – my father was dying and my Christian faith was subject to much reflection, strain and revision. Preoccupations within my study of French literature focused increasingly on existentialism, the nature of self, the notion and performance of gender, the meaning of time, the use made of language, and the concept of the absurd.

In parallel to this study, I read widely to try and locate my emerging ideas, and found that in the work of TS Eliot, Sartre and Beckett, I could somehow make sense of the world in relation to a meaning that was embodied in Beckett’s *Waiting for Godot* where Vladimir and Estragon had to keep on waiting (even if they could not understand what they were waiting for). Similarly, I was drawn to the work of Eliot (1944) where he asserted that ‘time present and time past are both perhaps present in time future and time future contained in time past’ and to Krapp in Beckett’s *Krapp’s Last Tape* (Beckett, 1958) who relentlessly listens and re-listens to his recorded diaries to try and understand who he was and perhaps is, albeit that the revelations are

often left as partial: ‘clear to me at last that the dark I have always struggled to keep under is in reality my most...’. From Sartre (1938), I drew on the concept of being ‘condemned to be free’ of having choices about who to be and to become, and yet not being able to avoid such choices, given the need to be ‘engaged’ in the existentialist project.

This existentialism was made most relevant for me in the work of Simone de Beauvoir, whose reflections on what it was to be an object in the eyes of others (to live ‘pour autrui’) and yet to seek to live in a way that made sense to oneself (‘pour soi’) were focused on the need to constantly have a project, to keep recreating who one is or wants to be. Beauvoir explored this in relation to gender in her famous assertion: ‘on ne nait pas femme, on le devient’ (one is not born a woman, one becomes one). This has been explored by Butler (1990) as one of the first clear expositions of what gender is in relation to sex, namely something that one gradually learns to ‘perform’ within a social context.

So where did this all bring me in the late 1980s? It brought me to an understanding of the world that might be characterised as a form of Christian existentialism, where one constantly creates and recreates oneself through a series of projects, defining oneself in relation to others (as object) and in the sum of those objects as ‘for oneself’. The forward motion, the need to keep on, or at least to wait, was somehow the meaning, or Eliot’s ‘still centre of the turning world’, and in the motion, the turmoil, was something still, albeit un-nameable as anything such as god. As a woman, this led me to a political position where much of what women feel they ‘have to be’ and the roles that feel expected to perform are a result of a process of socialisation, of being ‘other’

and ‘object’ in relation to men, seeking to create an authentic sense of ‘for oneself’ in a context of myriad images and interpretations of a female self.

To return to my career story, after graduation, I gained a place on the NHS General Management Training Scheme, a national programme of development for young managers, one which at the time had just been redesigned to be more concerned with ‘management’ than ‘administration’, reflecting the implementation of the Griffiths Inquiry into NHS management that took place in the 1980s (see chapter 2 policy context). For the educational element of my training, I was based at the Health Services Management Centre at the University of Birmingham. Following completion of the management training scheme, I held hospital management posts in Solihull and Coventry, spending a total of eight years as a hospital manager, and latterly as a manager of women and children’s services for Coventry.

Whilst working as a general manager in Coventry, I was asked by the NHS Women’s Unit (see chapter 2 policy context) to become part of their ‘register of senior women’ which was intended as a cohort of women with the potential to reach chief executive positions in a few years’ time. I joined the register and engaged in a number of development programmes, assessment centres, and career coaching activities offered by the NHS Women’s Unit. I also started study for a Masters in Business Administration degree, focusing on topics such as strategy, public policy, and creative management. This led me to question what I wanted to do in the longer run, and coincided with a time of restructuring and upheaval at the hospital where I was working.

I was interested in getting experience of NHS purchasing and primary care, areas of health management that were subject to rising profile in the early 1990s when the Thatcher internal market reforms were being put in place (see chapter 2). As part of a process of seeking advice about what to do next, and borne of some dissatisfaction with the relentless pressure of a senior management post that appeared to crowd out space for personal and home life, I went to see my former NHS General Management Training Scheme tutor at HSMC. This resulted in my being asked if I would like to come to HSMC on secondment. This I accepted, and took up a position in 1995, following which I applied for and was successful in gaining a substantive academic post in the centre a year later.

From 1996, I have been employed by the University of Birmingham in HSMC and have pursued research into the organisation and management of primary care, and commissioning. Parts of my experience that seem relevant to this research include my having become deputy director, and subsequently director, of the NHS Management Training Scheme educational programme for the UK – in this way returning not only to my original alma mater, but also to the training scheme I had chosen on leaving university.

During this time (2000-2003) I gave birth to two children. After the first birth, I returned to work full-time, as did my husband. We both continued to work full-time after our second child was born, but when the eldest started school, we decided to re-think how we organised our work and family lives, feeling that our children were lacking time and attention from us as parents. We decided that my husband would work reduced hours and do the after-school care two days a week, and I would work

my five days over four, and see to childcare on a Friday. After a year of this, in 2006 we made a decision to spend time overseas in New Zealand, as a chance to ‘get out of the rut’, write up my PhD, and have more family time together in a country that was close to my husband’s family in Australia. As part of this move, we agreed that my husband would give up his job in the UK, and take on the role of the main childcarer in New Zealand.

Reflecting on my story

So what to make of my own story of career being used as a prelude to the account of this research, a study that focuses on the stories of ten women chief executives? A core dilemma within this research is that of the ‘storying of self’ and how far such storytelling is concerned with a single narrative of an essential self, or with the construction, selection and presentation of multiple selves. As is revealed by the research process described in the following chapters, the study assumes a social constructionist position in the dialogical or poetic tradition (Shotter, 2008; Ford et al, 2008), whereby the crafting of multiple selves takes place through the constant and shifting interaction of speaker and listener, and in the case of this research, through analysis of women’s stories of career as co-constructed by researcher and respondents. A fundamental authorial dilemma I have therefore faced in writing this thesis has been concerned with choosing what to present (or not present) of my own story of career and self, given that in telling my story I necessarily construct, select and present different selves. This dilemma is one crucially concerned with reflexivity, and the extent to which I as a researcher have shaped and been shaped by the research, a topic that is examined in detail in chapter 4 (methodology).

The story of this research could be argued to be one of my deciding to study ‘what I chose not to become’, that is a woman chief executive in the NHS. My interest in the chief executives of primary care organisations may well have been on the face of it academic and a reasonable area of interest in relation to my wider research at HSMC. However, it also belied a personal history of general management, interest in gender and feminism, eschewing of hospital management, being part of a cohort of women managers encouraged by the NHS Women’s Unit, a cohort that I chose to leave. As the PhD research moved to focus increasingly on gender, so my story of trying to write a narrative of being a mother and a ‘career woman’ played itself out, my interest in women’s story of career and self interwove with my own, and revealed parallels with some of my own experience such as the negotiation of an arrangement whereby my husband is the lead childcarer. This reveals something of the reflexivity of the research, and how the PhD forms part of who I was, am and have been becoming – the different selves I construct and choose to present. In as much as the research represents something of the story of ten women leaders in the NHS, it perhaps reveals as much, if not more, of my own journey as a researcher, mother, wife, and colleague.

The story of the research

Knowing that this research ended up as an exploration of the stories of ten women chief executives, an examination of how they chose to tell their story of career and self, and a revelation of some of the dilemmas that appeared to be common within their experience, an account of the research’s genesis is inevitably an ‘beginning viewed from the end’. As noted earlier, the research was to map the population of primary care group and trust chief executives in England, and to use the findings as the basis for shaping a second, more in-depth and qualitative study of a sub-set of

those chief executives. In 2000 when shaping these ideas, the nature of that second phase of research was largely unformed in my mind and not thought through beyond ‘finding out what their support and development needs might be as a new cohort of NHS managers’ (Smith, 2000). What happened subsequently was that there was a break of almost two years in my research activity, largely due to having my first child and adapting to being a ‘working mother’. When I returned to my PhD studies in 2002, I chose to have new supervisors, and this is of significance in that from the outset they asked me questions including: Why are you interested in these chief executives? What makes you curious about their experience? Why primary care chief executives and not those in hospitals and mental health services? How does this relate to your own experience? This process of questioning led to a refocusing of the study’s aims and objectives and to a definitive plan of research that was drawn together into an application for ethical approval in late 2002. This led to the following set of research questions as set out in Box 1.2 overleaf.

Box 1.2: Research questions in March 2003

- Who are the chief executives of PCTs in England?
- In what ways, if any, do they differ from the wider population of chief executives in the NHS, ie chief executives of NHS trusts?
- What are the motivations and aspirations of PCT chief executives?
- To what extent, if any, do these motivations and aspirations change over time?
- What are the different components of the role of the PCT chief executives?
- To what extent, if any, do these role components change over time?
- How do PCT chief executives respond to the requirement to develop modern and innovative services, and what does this require of them?
- What lessons can be drawn for health policy, leadership and management, based on the experience of this group of NHS leaders?

The research question here concerns how far this population of health service leaders differs from the wider population of NHS chief executives. Possible areas of difference include:

- Gender – an assumption that a greater percentage of PCT chief executives are women
- Age – an assumption that a greater percentage of PCT chief executives are younger
- Chief executive experience – an assumption that a greater percentage are in their first chief executive post

It can be seen from this set of questions from March 2003 that a subtle shift had taken place within the research plans. Whilst the research questions about ‘difference’ of the primary care trust chief executive population remained, and the overall interest in exploring the population continued, there was now a focus on ‘digging deeper’ to explore the chief executives’ experience. Furthermore, when the research plans developed in 2003 are examined (see box 1.3 below) it is evident that the following had now happened:

- there was an intent to map the chief executive population of both primary care trusts and also NHS provider trusts, thus enabling a comparison of the two populations;
- there was a focus on using analysis of the mapping of the chief executive population to inform the design of the second stage of the research;
- it was suggested that the second stage would concentrate on examining the experience of primary care trust chief executives, but there was a hint that this was possible, rather than definite; and
- it was suggested that in stage two, there might be a mixed methods approach to exploring chief executives’ experience.

Box 1.3: Research plans in March 2003

Stage one

For the initial stage of the study, a mapping exercise of the current population of chief executives of PCTs and NHS trusts in England is to be carried out. This will enable an assessment to be made of the extent to which, if at all, PCT chief executives differ in their background and demography from chief executives of NHS trusts.

Stage two

Analysis of the data collected in the mapping survey will be used to describe the PCT chief executive population of PCTs in England and to draw comparisons with chief executives of NHS trusts. The analysis will also inform the design of the second stage of the study that is intended to be a more in-depth exploration of the role of PCT chief executives. This stage will be designed in conjunction with the PhD supervisor based on the findings of stage one, but is likely to take the form of a longitudinal study of a sub-set of PCT chief executives, exploring their management role and associated aspirations and motivations. A combination of methods, including survey questionnaires and semi-structured interviews is likely to be appropriate to this phase of the research.

At this stage in the research process (March 2003) an application was made for NHS research ethics approval, the application referring only to stage one of the research (the mapping element) for it was not at this stage possible to describe and hence seek approval for the second stage. Ethical approval was granted for a survey questionnaire to be sent all chief executives of primary care trusts and NHS trusts in England and this was sent out in April 2003, with a follow-up chaser process a month later, the overall response rate being 78%. Results of the questionnaire were analysed during 2005 following the researcher's return to work after maternity leave. As will be seen from findings set out in chapter 5 (mapping the context: national survey of NHS chief executives), a conclusion from this analysis was that gender was indeed an

area of significant difference between the primary care trust and NHS trust chief executive populations, as was age, and chief executive experience.

This process of analysis of survey findings, explored during PhD supervision, encouraged the bringing of me and my own experience into the thinking and analysis, and resulted in a decision to focus on the issue of gender within stage two of the research. More specifically, it was decided that a key puzzle was to try and understand something of the experience of women chief executives in NHS trusts and primary care trusts. This was borne out of a finding about the percentage of women chief executives in NHS trusts (and in particular in large and acute services trusts) not having changed significantly in over ten years, whereas the proportion of women leading primary care/community trusts appeared to have increased.

The desire that I now had to carry out in-depth exploration into the experiences of a small number of women chief executives (wanting to know what it was that motivated them, why they worked in a certain type of organisation, what it was like to be a chief executive, how they balanced the ‘rest of life’ with their job, etc.) reflected something of my own interest in being a working mother, my feminist ideas that had been shaped by the work of De Beauvoir, my fascination with the chief executive community that I had chosen not to join, and a belief that this population of chief executives, and of women, was one whose voice was rarely heard in relation to lived experience of being in such a leadership role in the NHS. This led to the development of research plans for phase two that are set out in box 1.4 below.

<i>Box 1.4: Research plans in May 2006</i>
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Repeat of postal survey questionnaire

A further postal questionnaire survey of all NHS PCT, trust (NHS trust, foundation trust and care trust) chief executives is to be carried out in autumn 2006 (almost identical to the survey carried out in 2003), as a means of tracking any further change in the chief executive population and to identify any impact on chief executive demography of the NHS reorganisation associated with 'Commissioning a Patient-Led NHS' (Department of Health, 2005) that was being implemented in PCTs in England in 2006.

In-depth interviews with women chief executives

A more extensive exploration of the role and experience of women chief executives through in-depth semi-structured interviews, is to be carried out in November-December 2006 and analysed using narrative analysis techniques. This element was designed in conjunction with PhD supervisors based on the findings of stage one research and a review of the literature concerned with NHS chief executives, women in health services management, and discourse and narrative psychology and analysis.

The overall aim of this stage two research was to undertake detailed analysis of the role and experience of women chief executives in the NHS, and to update the national demographic profile of NHS chief executives created following stage one PhD study. The questions for the research carried out in 2006 are set out in box 1.5 overleaf.

Box 1.5: Research questions in May 2006

The **primary research question in 2006** was to explore whether or not gender was a significant factor in the 'difference' of PCT chief executives from their NHS trust counterparts.

Secondary research questions in 2006 were:

- that there were specific factors associated with PCTs that made women more likely to choose a chief executive role in a PCT, rather than in an NHS trust.

- that there were specific factors associated with NHS trusts that made women less likely to choose a chief executive role in an NHS trust, rather than in a PCT.

- that women's motivations about choice of career within health services differed, to some extent, from those of men.

- that there were specific factors that affected the career choices of women within health services management.

- that there continued to be some sex-role stereotyping of women's roles in health services management (as noted by Alban-Metcalf, 1989) and that this affected the gender balance of the overall NHS chief executive population.

- that women might conceptualise the role and skill-set of a health service chief executive in a different way from their male counterparts.

- that women health service chief executives might set different business and organisational priorities from those of their male equivalents.

- that there were factors associated with large NHS trusts that dissuaded women from applying for chief executive posts in such organisations.

The postal survey questionnaire of all NHS trust and PCT chief executives in England was carried out for a second time in November 2006, with a follow-up chaser one month later. The response rate in 2006 was 62%, and analysis of survey results revealed that whilst the proportion of women had increased further within PCTs (where they were now in the majority), it continued to be much as before within NHS trusts. There was no longer a significant age difference between PCT and trust chief executive populations, and there appeared to have been a ‘maturing’ of the PCT chief executive population where there was now a lower percentage of people who were in their first substantive chief executive post. The findings of this survey were used as context to the final analysis and writing up of the PhD research.

In parallel to carrying out the repeat postal survey questionnaire, a set of ten semi-structured and in-depth interviews was carried out with five PCT chief executives and five NHS trust chief executives, all of whom were women. The women were asked to tell their ‘story of career’ and were then prompted with a series of questions designed to explore: their reasons for choosing to be a chief executive; factors that had influenced career choices; factors that had motivated them in their chief executive role, their business and organisational priorities for their role, the sense they made of their role, and career plans and intentions for the future. The accounts gathered in these interviews were analysed using narrative analysis techniques and within a pluralistic theoretical framework that drew primarily on the dialogical school of social constructionism - one that was designed to explore the construction and presentation of career and self, with a focus on how the women used language as a means of developing multiple and shifting ‘crafted selves’ (Kondo, 1990).

The structure of this thesis has been designed in order to report on the research in a way which reflects the journey taken by the study. In the next section of this chapter, a map is set out of the overall thesis, explaining what is within each chapter and how that relates to the overall research process, findings, and conclusions.

The structure of the thesis

In **chapter one (introduction)** of this thesis, an account has been given of the overall ‘story of the research’ with a particular focus on why I was interested in the topic of NHS chief executives and gender, how my personal story of career relates to the research, and the way in which research questions and interests evolved over the course of the study, and were enacted through different research methods.

In **chapter two (policy context)** an exploration is made of the policy context of the National Health Service (NHS) in England, in order to set the scene for the reporting of findings of research into the NHS trust and primary care trust chief executive population in 2003 and 2006. A history of health policy from 1979 is set out, focusing on developments relevant to three particular aspects of health management examined in this research, namely the role and expectations of senior managers in the NHS, the emergence of two communities of health management, hospital /provider and primary care/purchaser, and a growing concern about equal opportunities in the NHS. In addition, a summary of the background to the establishment of the NHS is given, in order to explain the historical context to the twin tracks of hospital/provider and primary care/purchaser management.

Chapter 3 (literature review) explores academic and policy literature related to the core questions of this research study and seeks to locate the PhD research within the wider literature. Three bodies of literature are examined in the chapter: the demography of health services management in the NHS; gender in organisational life; and the storytelling of career and self. The studies, theories and concepts of most relevance to the questions being asked in this study are identified, and a literature-based conceptual framework is developed within which the project's findings were subsequently analysed and reported.

Chapter 4 (methodology) describes, explains and reflects on the methodological approach used for this study. Firstly, the research questions are set out, along with an explanation of how analysis of data collected for the first stage of the study informed the development of questions for the second stage. Secondly, an explanation is given of the methods of data collection and analysis used to address the research questions. In the third section, the overall theoretical approach to the research is set out, with a particular focus on how this related to the methodologies selected, and the ways in which research data were analysed. The fourth section then explores the methods used in analysing data, with a particular focus on the narrative analysis of the ten chief executives' accounts, and including a reflection on the nature of my own reflexivity within the research. The fifth and final section of the chapter reflects on the methods used in the study, and considers how far they facilitated the drawing of conclusions that are both relevant the project's aims and also enable a distinctive contribution to be made to the literature on health care management and leadership.

In chapter 5 (mapping the context: national survey of NHS chief executives) an account is given of the two postal survey questionnaires of NHS chief executives carried out as part of this study, one in 2003 and the second in 2006. The rationale for the surveys is described, and results are presented in a way that enables comparisons of key themes over the period 2003-2006. Specific themes related to the NHS chief executive population explored within data analysis include: gender; age; salary; ethnicity; disability; employment status; length of time in post; and prior post and organisation. Conclusions are drawn about the nature of the chief executive population in 2003 and 2006, and key areas of difference between PCT and NHS trust cohorts are identified in each of these two years. Overall conclusions focus on changes apparently taking place within the PCT chief executive population and on the position of women within the overall and also sector-specific chief executive population.

In chapter 6 (hearing the stories told by the women chief executives) the other main element of data collection is reported, namely the interviews with ten women chief executives carried out in late 2006. A narrative analysis is made of the 'core stories' distilled from the accounts given by the ten women, this analysis having been carried out within a conceptual framework that considered the accounts to reveal a number of dilemmas faced by the women as they sought to present a story of multiple, shifting and 'crafted selves' (Kondo, 1990). Six such dilemmas were identified: i) to where or whom should I ascribe my success? ii) how far should I acknowledge the support of male sponsors? iii) how can I reconcile my role as a mother with that of being a chief executive? iv) what have my career choices meant for my partner's role and career? v) how can I reconcile personal and organisational values? vi) and have I

adapted to the predominant male archetype of leader by becoming ‘male’? The chapter concludes with a brief discussion of what these six dilemmas reveal about the women’s presentation of career and self, and sets the scene for chapter 7 which discusses the themes emerging from the narrative analysis of the ten stories together with the messages from the survey questionnaire.

Chapter 7 (discussion) explores the overall findings from the research.

Consideration is given to the conclusions to be drawn from the two national surveys of NHS chief executives, followed by an exploration of the six dilemmas identified as part of the analysis of narrative accounts given by ten women chief executives as set out in the previous chapter. The examination of each dilemma draws on relevant literature and seeks to locate the expressed experience of the ten women chief executives within a wider body of evidence about gender, organisation and leadership. The chapter concludes with speculation about the gendering of the NHS chief executive work environment, an exploration of what the women might otherwise have talked about in their stories, and considers the issues inherent in trying to craft a self or selves when telling a story of career.

The final **chapter 8 (conclusions)** draws together the key themes and findings from the research and sets out the original contribution to knowledge made by the thesis.

The original contribution is asserted to include the following: a mapping of the chief executive population of the NHS in England and revelation of persisting lack of representation of women, ethnic minorities, and disabled people at chief executive level; a contribution to the body of literature and knowledge on conceptualising women in senior roles, in particular in relation to the ‘anxieties’ they experience; an

important addition to the social constructionist methodological literature in the field of leadership; and a set of policy implications for the NHS in relation to its model and practice of leadership. Furthermore, consideration is given the questions raised in this thesis that would be worthy of further research, and a reflection is made on the overall process of having conducted this PhD study.

Chapter summary

This chapter has set out the overall ‘story of the research’ with a particular focus on why I was interested in the topic of NHS chief executives and gender, how my personal story of career relates to the research, and the way in which research questions and interests evolved over the course of the study. Furthermore, it demonstrates how a pluralistic theoretical framework located in the dialogical tradition was used to inform the selection of a range of methods for data collection and analysis, and hence to explore women’s accounts of their experience as chief executives as ‘stories of career and self’. It also maps out the structure and content of the thesis, and sets the scene for the material that follows related to policy context, literature review, methods, research findings, discussion and conclusions.

CHAPTER 2

POLICY CONTEXT

Introduction

This chapter explores the policy context of the National Health Service (NHS) in England, in order to set the scene for the reporting of findings of research into the NHS trust and primary care trust chief executive population in 2003 and 2006. It sets out a history of health policy from 1979, focusing on developments relevant to three particular aspects of health management examined in this research, namely the role and expectations of senior managers in the NHS, the emergence of two communities of health management, hospital /provider and primary care/purchaser, and a growing concern for equal opportunities in the NHS. In addition, a summary of the background to the establishment of the NHS is given, in order to explain the historical context to the twin tracks of hospital/provider and primary care/purchaser management. The time period for the main content of this policy review covers from 1979 to 2007. The choice of this time period reflects the fact that the chief executives interviewed for this study commenced their NHS management career in or later than 1979.

Background: the establishment of a national health service with two administrative communities

Prior to 1948 and the foundation of the NHS, health services in Britain were made up of a complex mix of public and private provision, including voluntary hospitals, private general practitioners (GPs), friendly society 'club practice', and community services run by local government. GPs were private practitioners who charged fees to patients, and some people subscribed to friendly societies that hired doctors on behalf

of members, hence 'club practice'. It has been argued that club practice was the start of a movement for a national health service, given that the conditions it imposed on doctors made a frustrated medical profession receptive to state intervention (Honigsbaum, 1990).

Voluntary hospitals were charitable institutions that gave care free of charge, with doctors making money by treating the rich at home, whose charitable contributions in turn supported the hospital. There was evidence of hospitals being selective in relation to who they treated (Abel-Smith, 1964) with the very poor often denied access. By the late 1930s, hospitals were charging patients to a greater extent and hence insurance plans were established to cover such payments (Baggott, 2004). Public health services meanwhile were run by local authorities, including isolation hospitals, maternity care, and mental hospitals. These services had evolved from the system of public relief set up by the Poor Law Amendment Act (1834), which included workhouses and Poor Law infirmaries. As public health legislation was gradually introduced to tackle issues of sanitation, water supply and pollution control, local health committees were set up to administer such services, under the leadership of local medical officers of health (Baggott, 2004).

As debate took place in the 1940s about the proposed establishment of a comprehensive national health service for Britain, two main groupings emerged within the medical profession, groupings that had their roots in the traditional nineteenth century division between physicians and surgeons who practised in hospitals (specialists), and apothecaries who practised in the community and came to be known as general practitioners (Ham, 2004). In setting up the NHS, the Minister

for Health Aneurin Bevan had to negotiate with these two medical groupings. The GPs fought to avoid a system of salaried general practice and won the right to remain as independent contractors who would provide services on the basis of a contract negotiated between representatives of the profession and the Ministry of Health. Hospital doctors meanwhile won the right to continue to carry out private practice alongside NHS work, and to earn merit awards, together with generous salary provision (Ham, 2004).

These negotiations, together with the pre-existing structure of health services in Britain in the 1940s, meant that from the outset of the NHS, there was a bifurcation in the management and administration associated with primary care/general practice on the one hand, and hospital services on the other. This bifurcation was embodied in organisational structures - in 1948, a separate administrative branch was set up to handle general practice contracts, together with those of opticians, pharmacists and dentists, and this resulted in the establishment of local executive councils. Hospitals were administered by hospital management committees (and via boards of governors for teaching hospitals), while community and public health services remained the responsibility of local authorities.

Over the period 1948 to 1979, the primary care element of health administration remained under the guardianship of executive councils until 1974 when reorganisation of the NHS resulted in the creation of family practitioner committees (FPCs) that continued to manage the contracts of GPs, dentists, pharmacists and opticians. This reorganisation saw community and public health services integrated into NHS management structures along with hospitals. It is of note that primary care/general

practice administration in the form of FPCs continued in its more independent or ‘arm’s length’ arrangement, reflecting the staunch independence of general practice as expressed in its 1948 negotiations with government. Indeed, it was not until the Thatcher reforms of 1989 that FPCs were shifted from a largely administrative to a more managerial basis when reformed as family health services authorities (FHSAs) who were to develop and manage primary care, albeit that they remained separate from district health authorities whose role was to purchase hospital and community health services.

In the following sections, policy related to the development of NHS management is examined, with reference to the two management communities of primary care on the one hand, and hospital and community health services on the other.

The National Health Service in the 1980s: general management and the internal market

Responding to the Royal Commission

The Labour government of the late 1970s established a Royal Commission to consider ‘the best use and management of financial and manpower resources of the NHS’ (Cmnd 7615, 1979, p1). This was in response to a number of pressures faced by the NHS at this time including: industrial action among various groups of NHS staff; concerns about quality of care highlighted by scandals in some long-stay hospitals; long waiting lists for treatment; and a sense of falling public confidence in the service (Baggott, 2004). The Royal Commission’s findings in some ways represented a policy bridge between the Labour and incoming Conservative governments, with the

latter accepting some of the recommendations and conclusions of the Commission. In a consultative paper entitled *Patients First* (DHSS and Welsh Office, 1979), the incoming Conservative health minister Patrick Jenkin summarised the Royal Commission report by asserting that the NHS' problem was having too many tiers, too many administrators, a failure to take quick decisions, and a waste of money (Rivett, 1998). In *Patients First*, the Conservatives suggested that what was needed in the NHS was: stronger local management with greater delegation; a streamlined structure with removal of the area tier; simpler professional advisory machinery; and a simpler planning system.

The abolition of area health authorities was announced, along with proposals for 192 district health authorities. There was however no mention of change to the family practitioner committees, primary care administration once again being treated as 'different' from its hospital and community health services cousins, and left to some extent to one side. District health authorities were to be responsible for the planning, development and management of hospital, community, mental illness and mental handicap (sic) services, with a management team of six, including two clinicians (a consultant and a GP) and a community physician.

At this stage, the focus of NHS management was on what was known as 'consensus management' a principle whose formal introduction to the NHS in 1974 was described by Harrison as:

'an extension and formalization of a *de facto* practice which had been gaining ground in the N.H.S. over a number of years'. (Harrison, 1982 p379)

Day and Klein (1983) considered consensus management as being:

‘born of the acknowledgement that implementing policies in the NHS requires the voluntary co-operation of doctors, nurses, and others.[...] They are administering history, - and adapting it at the edges – rather than planning for the future.’ (p1815).

Harrison (1988), in a review of evidence about consensus management, identified six criticisms that could be levelled at the approach: trivial issues were dealt with as consensus items; accountability was weakened by the process; it slowed decision-making; teams were under excessive pressure to achieve consensus; it produced weak decisions; and teams were susceptible to domination by a strong personality. He concluded however that there were few prospects of making significant improvements to consensus management as a process of decision-making in the NHS, given the context of medical dominance in relation to defining the purpose and funding of health services.

The early Conservative years

In their early days, the Conservative government of 1979 paid relatively little attention to the NHS and did not seek to make wide-reaching reforms. This was in contrast to the overall approach of the government towards public services, for Margaret Thatcher was considered to have a style and perspective that represented a considerable break with the past, being closely associated with New Right politics (Jenkins, 1987; Young, 1991; Baggott, 2004). Baggott characterises the Thatcher administration as follows:

‘the Thatcher Governments attempted to transform many aspects of the postwar settlement, favouring private sector solutions to those offered by the public sector, privatisation to nationalisation, lower taxes above public spending, deregulation to state control. [...] The Thatcher Governments also pursued a managerialist approach to public services. This led to an increased emphasis upon private sector management principles and techniques, a

stronger focus on efficiency, cost control, and performance measurement, and ultimately processes that were intended to mimic market mechanisms'. (Baggott, 2004, p99)

This summary of the approach taken by the Thatcher Government sets the context for the shift in focus from administration to general management that took place in the NHS in the 1980s, and bears witness to the shift towards New Public Management (Pollitt, 1991) that characterised the 1980s and 1990s public services in the UK. New Public Management drew on the ideas of Osborne and Gaebler (1992) who argued that public organisations should 'steer' (purchase or influence the purchasing of a service) and not necessarily 'row' (provide the service). This distinction is returned to later in the chapter when the internal market reforms of 1979 are examined.

The Griffiths Management Inquiry

It has been argued that until the mid-1980s, management in the NHS was concerned with accommodating the dominance of doctors and that this was reflected in formal management structures (the consensus management referred to above). Harrison (1988, p51) noted that

'Managers neither were, nor were supposed to be, influential with respect to doctors...Managers in general worked to solve problems and to maintain their organisations rather than to secure major change'. (Harrison, 1988, p51)

After the 1983 general election, Norman Fowler, Secretary of State for Health, established an inquiry into the state of NHS management, and has explained his rationale as follows:

'It's extraordinary that we were 40 years into the health service and we hadn't got to the point of addressing the management issues properly. Even great

people like Keith Joseph would talk approvingly of consensus management, which was so obviously inadequate – consensus management was basically a way of avoiding decisions.’ (Fowler, in Timmins, 2008 p40)

Fowler turned to business for advice, as was often the preferred approach of the Thatcher government. He asked a small group of business people, under the chairmanship of Sir Roy Griffiths, deputy chair and managing director of Sainsbury’s supermarkets, to advise on the effective use of management and manpower and related resources in the NHS. In a short report, Griffiths identified the lack of general management as what for him was a key deficiency within the NHS and famously commented that ‘if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge’ (NHS Management Inquiry, 1983, p 12). The recommendations of the Griffiths review included:

- a general manager (regardless of discipline) should be identified at all levels of the NHS with greater freedom to organise the management structure to suit their needs;
- there should be a clear accountability review system starting centrally and establishing a chain of command through to unit managers;
- there should be a reduction in the number and levels of staff involved in decision-making and implementation; and
- clinicians should be more closely involved in management decisions, having a management budget and necessary administrative support.

These recommendations have been assessed as being at once radical and vague, with ‘only the sketchiest account of the functions of various new institutions’ (Harrison and Wood, 1999, p756). Day and Klein (1983) used the term ‘heroic oversimplification’ in their critique of the report, pointing out that a technical or managerial ‘fix’ was not sufficient to address the problems of the NHS, which they regarded as much more complex and inherently political.

Griffiths asserted however that the absence of general management in the NHS was a key cause of many of its problems and it is for the introduction of general management that the Inquiry continues to be best known to this day. Warnings were sounded about the challenge to be faced in following through the logic of the Griffiths proposals. For example, Day and Klein noted:

‘If the health system is to move from one that is based on the mobilisation of consent to one based on the management of conflict – from one that has conceded to the right of a variety of groups to veto change to one that gives the managers the right to override objections – then the process is going to mean radical and perhaps painful change.’ (Day and Klein, 1983, p1813)

The government accepted the Griffiths proposals, including that general management – ‘the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance’ – should be put in place throughout the different levels of the NHS (regions, districts, and management units). There was a desire to recruit general managers from outside the NHS and hence beyond the pool of ‘traditional NHS administrators’. However, in reality, the majority of those appointed were in fact from an NHS background, albeit that some were from a nursing or medical background (Disken et al, 1987).

The fostering of a more entrepreneurial culture in the NHS was encouraged by measures such as the introduction of more attractive remuneration for managers, the development of performance-related pay, and policy exhortation of income generation as an approach to financial management. This all prefigured the introduction of the NHS market at the start of the 1990s, and hence the Griffiths review can be seen in retrospect to have been part of the Conservative government's attempt to make the NHS more business-like and commercial in its approach (Edwards, 1993; Baggott, 2004).

The extent to which general management actually turned out to be the radical culture change it intended has been explored in research and policy analysis, with conclusions being drawn about the persisting importance of managerial-clinical relations and the way in which these tend to mitigate against radical change. For example, a major study of the impact of the implementation of general management in the NHS was carried out by Chris Pollitt, Steve Harrison, David Hunter and colleagues, funded by the Economic and Social Research Council. This study confirmed the observation from the Dopson and Stewart tracer studies (see chapter 3 literature review) about a lack of significant change to the actual management task as district administrators became district general managers. Pollitt et al (1991) concluded that although general management appeared to have been widely accepted in the NHS, and had resulted in some improvements to management processes, there had been no substantial change in organisational culture, with medical autonomy and financial limitations continuing to be the major influences on the NHS (this echoing Harrison's earlier critique of consensus management). It was noted that the Griffiths changes had not resulted in a

restructuring in the relationships between managers and doctors, and that the impact of general management varied considerably across authorities. The authors surmised that the Griffiths model was inadequate, noting that the Griffiths model was: founded in distrust, in comparison with the trust-focused consensus management approach; lacked a convincing analysis of the relationship between running the NHS and the workings of the wider political system; was introduced into a service that lacked clear overall objectives; and assumed a scientific rational approach to management that was neither appropriate nor possible in the cultural and political domain of the NHS (Pollitt et al, 1991).

The NHS internal market

By the late 1980s, the Conservative government faced a range of pressures in the health service that made it inevitable that Thatcher's reforming zeal would turn its attention to the NHS. The problems besetting the NHS at this time were summarised by Jennifer Dixon in a book reflecting on the experience of implementing the NHS internal market:

‘There was an overriding imperative to curb the growth in spending on the Service to keep public expenditure down: unacceptably large variations in performance in different areas were apparent; there was a marked lack of information and choice for consumers; the Service was insufficiently managed; and there was almost no reason for the medical profession to consider the costs of treatment even though the NHS operated within a cash-limited budget. Furthermore, perennial problems such as long waiting lists and times, ward closures, staff shortages and difficulties in admitting emergency cases remained stubbornly difficult to solve’. (Dixon, 1998, p3)

In addition to the introduction of general management to the NHS, a range of initiatives during the 1980s had attempted to encourage greater efficiency into the NHS. These included cost improvement programmes, the extension of the remit of

the Audit Commission to cover the NHS, the resource management initiative that sought to devolve budgets within hospitals to clinical directorates, and the introduction of compulsory competitive tendering for ancillary services from a range of competing providers. These developments were not, however, addressing some of the fundamental problems facing the NHS in the late 1980s, including variations in clinical practice, the general lack of responsiveness of the NHS towards patients, and rising demand that fuelled a financial crisis.

In the winter of 1987, following a well-publicised case of a child in Birmingham who died when a life-saving operation was cancelled due to lack of intensive care nurses, Margaret Thatcher announced a wide-ranging review of the NHS. The review was initially intended to be far-reaching and to consider alternative methods of financing, providing, and organising health services (Thatcher, 1993). However, alternative approaches to funding were dismissed at an early stage and did not feature in the subsequent white paper in 1989. The ideas of Alain Enthoven from the USA, and also those of Alan Maynard and Nick Bosanquet from the UK were influential in the review, particularly those concerned with splitting purchasing from providing in the NHS, allowing providers to compete for NHS funds and be rewarded for quality and efficiency, and giving GPs budgets with which to purchase hospital and community services (Enthoven, 1985; Maynard, 1986; Dixon, 1998).

The review resulted in a white paper *Working for Patients* (Cm555, 1989), published in January 1989. The overall aims of the white paper were to improve value for money, reward efficient and higher quality providers, and encourage greater responsiveness of services to patients. The white paper reflected the Conservative

government's focus on individual consumer service within public services, and represented a challenge to the status quo – the rigidity of the organisation of the NHS, and the associated assumption that the presence of highly trained professionals would ensure that users got what they wanted (Plamping, 1991). The main proposals set out in *Working for Patients* were focused on reform of the organisation of the NHS and included:

- the separation of purchaser and provider functions, with district health authorities becoming purchasers and losing their service management responsibilities;
- hospitals, mental health providers and community trusts could apply for self-governing status as NHS trusts;
- GP practices with a population of 11,000 or more could apply to become 'GP fundholders', taking on purchasing budgets for pharmaceuticals, outpatient care, community health services, and some elective hospital procedures; and
- regional, district and family health services authorities were reduced in size and reformed on business lines, with executive and non-executive directors.

The logic underpinning the reforms was that as money would no longer flow automatically from purchaser to provider. Providers (self-governing trusts) would have to compete for business. It was asserted that the resulting competition would encourage providers to be more efficient, more responsive, and offer better quality care (Dixon, 1998). Furthermore, commentators noted the potential for more explicit

specification of services, better pricing of improvements, and a move of rationing decisions away from doctors into the public arena (Plamping, 1991). The term 'internal market' was coined as shorthand for the reform process, implying that both the buying and selling of services would happen within the NHS. This was not wholly accurate because purchasers were able to buy care from private providers. A further term that was used to describe the Thatcher reforms was 'quasi-market' (Le Grand and Bartlett, 1993).

It is of note that the Thatcher reforms, unlike previous health management reforms, explicitly sought to exploit the unusual nature of the policy compromise that had been reached in 1948, namely the separate administrative and reporting requirements for primary care/general practice as opposed to hospital and community health services. In the *Working for Patients* reforms, the Thatcher government offered practices the opportunity to be purchasers of health care on behalf of their practice population, and buying such services from providers who were hospitals and community trusts managed by district health authorities. In so doing, there was arguably an attempt to draw general practice more firmly into the ambit of NHS management (or at least the planning and purchasing element), and to take advantage of the administrative 'separateness' of primary care to position general practice as purchasers of services from hospitals and community trusts. Indeed, Klein (1995) in a critical review of the NHS internal market reforms asserted that whilst the political aims of the reforms in relation to patient choice and staff satisfaction had largely gone un-met during implementation, he noted that two important side-effects of the changes: the increased status and influence of GPs in the health system; and the persuasion of the medical profession to accept more collective responsibility for how they practised.

It can also be asserted that these reforms established distinctive strands of NHS management that reflected the ‘rowing’ and ‘steering’ of New Public Management. Firstly, provider or trust management (the rowing) that was to focus on the management of hospitals, mental health organisations, and community health services, now being clearly separated from the planning and funding responsibilities previously vested in district health authorities. Secondly, purchaser management (in the form of district health authorities and GP fundholders) was now identified as a specific strand of health management (the steering), and one that would require separate and focused capacity and development.

The changes to NHS organisation and management put in place by the Conservative Government, although not subject to formal evaluation commissioned by the NHS itself, attracted significant critique and analysis among health policy researchers and commentators. Klein described the Thatcher government as:

‘disdaining consensus, experiment, and incrementalism and overriding strident opposition from the medical profession and others – introduced and implemented systemwide changes: a big bang approach to health care reform.’ (Klein, 1995, p300)

Debate covered issues such as how far the reforms would lead to a change in management practice and culture, how far market principles would be pursued, the extent to which patients would really find themselves at the heart of planning and management practice, and whether or not the incentives and levers within the internal market were sufficiently strong to bring about the changes to patient services discussed in the white paper. Klein (1995, p331) presciently concluded:

‘the 1991 reforms have clearly shifted the grounds of debate: familiar issues have been placed in a new landscape. The separation between purchasers and providers is likely to survive. The question has become how best that is managed [...] Similarly, an institutional framework for health care must take into account the fact that the 1991 reforms have blurred traditional concepts of the dividing line between public and private organizational forms.’

Ashburner et al (1996) carried out research within a set of 11 case study NHS organisations, along with two surveys of members of health authority and trust boards. They explored the extent of organisational change resulting from the Thatcher internal market reforms, and concluded that:

‘our overall view is that the scale and scope of the change observed in the NHS seem to be of great significance [...] the NHS, at least as viewed from board level, is currently at the early stages of an ‘organizational transformation’ (Ashburner et al, 1996, p 13).

They attributed this to the nature of political leadership of the changes, general management being a group that was gaining from the reforms, and the splitting of the medical profession into winners (GP fundholders) and losers (specialists) resulting in diluted opposition from doctors. Ashburner et al concluded that whilst an imported culture (market values and approach) could not totally supplant the host NHS culture, an ‘unintended hybrid’ (op cit, p13) of New Public Management might emerge as the old public administration culture changed to respond to the threat of the new. That these researchers cited the new general management cadre as winners from the Thatcher reforms, and hence relatively enthusiastic adopters of the internal market approach, suggests that this was a time of potentially significant change to the NHS management task and culture.

Others such as Stewart and Walsh (1992) noted that:

‘the national health service is changing from being an integrated, hierarchical bureaucracy to becoming a dispersed network of organizations interacting on increasingly market-based principles.’ (Stewart and Walsh, 1992, p502).

In a critique of the changes being made by the Thatcher Government to public services in general (i.e. not just in the NHS), these authors warned of the risks of over-simplifying the transfer of private sector management approaches into the public domain, on the basis that there were distinctive tasks, purposes and conditions that needed to be recognised and that would likely limit the application of such approaches within public services.

In the next section of this chapter, the development of one particular aspect of the New Public Management changes within the NHS, the two strands of NHS management (provider/’rowing’ and purchaser/’steering’) is examined within the context of implementation of the internal market reforms and subsequent policy direction set by the incoming Labour government in 1997. This sets the scene for reporting the research within this thesis which sought to map the populations of provider and purchaser management communities in 2003 and 2006, and to explore the nature of those populations as a basis for more in-depth study of the role and experience of a specific cohort of chief executives.

The National Health Service in the 1990s: the parallel development of two management communities

The *Working for Patients* reforms were enacted by the NHS and Community Care Act 1990, and whilst the legislation passed through parliament with relative ease, on

account of the government's majority, with implementation came an arguably more cautious approach (Baggott, 2004). In 1991, a general election was looming, so commercial language started to be toned down, and in place of 'purchasing' and 'markets' the talk was more of 'commissioning' (Ham, 2000). Implementation of changes such as self-governing trusts and GP fundholding were phased in annual 'waves' between 1991 and the mid-1990s. Other reforms such as the use of contracts were likewise put in place with a degree of caution, as block contracts were used in the first instance and a 'steady state' was called for. Dixon commented that:

'The tidal wave of cut-throat competition which had threatened to crash over the NHS turned out to be little more than a gentle wave lapping at its edges. Indeed, the word competition lost currency and was replaced by "contestability" or potential for competition'. (Dixon, 1998, p12)

The Major Conservative government

In 1990, Margaret Thatcher was ousted as Conservative Party leader and Prime Minister and succeeded by John Major. The Major government committed itself to continuing with implementation of the NHS internal market and so the roll-outs of GP fundholding and NHS trusts got under way. Once the 1992 general election had been won by the Conservatives, elements of the reforms were speeded up again, for example with the opening up of the GP fundholding scheme to smaller practices than had initially been the case. Likewise with NHS trusts, a policy of self-governing that had only initially been open to hospitals, was extended to community health services. Competition was not as extensive as had been anticipated, with trust mergers taking place, and district health authorities showing themselves to be unwilling to 'rock the boat' significantly in relation to threatening the viability of local hospital services (Dixon, 1998). Mergers also took place between district health authorities, whose

numbers fell from 192 to 100 between 1991 and 1995. Interestingly, the creation of these ‘new health authorities’ (as they were termed in policy) entailed the merger of district health authorities and family health services authorities. For the first time since 1948 therefore, the management and administration of the purchasing and planning of primary and secondary care was combined into a single organisational form, albeit that the management of service provision remained within separate tracks (of general practice/health authorities and NHS trusts respectively). This development prefigured the creation in 2002 of primary care trusts with a responsibility for purchasing primary and secondary care. Now there was clear organisational form to the two main strands of NHS management, the one focused on purchasing/primary care (the new health authorities) and the other provision (NHS trusts).

NHS trusts

There was very little research carried out into the implementation and development of NHS trusts, a fact commented on in the King’s Fund review of evidence concerning the NHS market. This review (Le Grand et al, 1998) pointed out that the Conservative government was reluctant to allow any evaluation of its reforms, yet a much larger amount of research was carried out in GP fundholding and purchasing than in NHS trusts. Perhaps this was on account of the relative independence of general practice, in comparison with the managerial accountability of NHS trusts to the Secretary of State, which gave them much less freedom of manoeuvre in commissioning any evaluative studies or being seen to question national policy direction. Thus we are left with an impression of NHS trusts as organisations that were seeking to operate to more business-like principles than their predecessor

management units, possibly, as noted by Ashburner et al (1996) due to the apparent congruence between general management and the internal market reforms. NHS trusts had boards formed in the corporate model of executives and non-executives. They had to account for capital via a capital charging scheme, were required to compete for contracts from GP fundholders and health authorities, and had an accountability regime that despite assertions of local control and autonomy, required reporting directly to the NHS Management Executive (Hamblin, 1998; Baggott, 2004). Whilst trusts in the 1990s largely escaped the requirements for reorganisation experienced by purchasers (see below), there was often pressure to merge trusts into larger organisations, especially where financial pressures were experienced.

The strengthening of primary care management

‘Primary care organisation’ is a term that entered the NHS lexicon from the early 1990s onwards (Peckham and Exworthy, 2003; Smith and Goodwin, 2006), reflecting the policy focus on developing stronger primary health care and a greater range of services outside hospitals. This policy focus originated in the publication of the White Paper *Promoting Better Health* in 1987 (Cm 249, 1987) that led to the implementation of the new GP contract in 1990. Measures resulting from *Promoting Better Health* included specific payments to GPs for achieving targets for health screening, incentives for practices to recruit nurses, and other inducements aimed at encouraging a greater degree of chronic disease management and health promotion within primary care (Peckham and Exworthy, 2003). The responsibility for implementing these changes at a local level fell to the family health services authorities that had taken the place of the former family practitioner committees following implementation of *Promoting Better Health* and *Working for Patients*.

Alongside the development of primary care management via purchasing and payments administration (family practitioner committees and then family health services authorities), another cadre of primary care management was emerging within the NHS during the 1990s. Following the NHS and Community Care Act of 1990 the introduction of GP fundholding led to the employment of many new managers within practices and networks of practices. This was because of the need for information collection, contract management, negotiation with providers, and the other tasks associated with supporting GP purchasers within the NHS internal market (Smith et al, 1997; Mays et al, 2001). GP fundholding did not only take place at a practice level. Fundholders quickly evolved a range of organisational forms within which to manage and co-ordinate their purchasing activity, and soon there were many GP multifunds, fundholding consortia, and other organisations in place throughout the NHS. These were financed by a pooling of the management resource made available to GPs when signing up to the fundholding scheme, and enabled the development of a new cadre of purchasing and service development managers based in primary care. A further development of fundholding was introduced in the mid-1990s when a set of national pilot 'total purchasing projects' (TPPs) was established, within which practices or groups of practices were able to assume a total health purchasing budget on behalf of their registered practice population.

Approximately half of GPs eventually joined the GP fundholding scheme and its variants such as total purchasing. Many of the others chose to develop parallel arrangements for having some influence over health planning and purchasing, preferring to work in partnership with district health authorities (and later the new

health authorities) in what came to be known as GP or locality commissioning groups. In the mid-1990s, the Major government realised that this diversity of primary care-led purchasing organisations was a reality that was not going to go away. Rather than try to force everyone into the fundholding scheme, the Major government developed policy guidance underlining the value of a ‘primary care-led NHS’ (NHS Executive, 1994), calling for health authorities to work closely with primary care, ideally through fundholding, but otherwise in collaborative GP commissioning schemes.

Studies of these new primary care organisations reveal a strong desire on the part of the GPs and health authorities leading their development to find appropriate levels of management support, and help to explain the emergence of the new primary care management cadre. Smith et al (1997) highlighted what they saw as a shift towards more senior and professional management of GP fundholding and commissioning bodies:

‘More senior general managerial appointments are being made in primary care as witnessed by the chief executive roles for multifunds, project managers for TPPs [total purchasing projects] and commissioning managers for GP commissioning groups. That new organisations are fostering the development of new roles can be likened to the move in the industrial revolution from cottage industries to small businesses or companies.’ (Smith et al, 1997, p37).

The two health management communities

Thus at the end of the Conservative years of government, the NHS had two broad health management communities. Firstly, a provider trust management grouping (New Public Management’s ‘rowers’) that was very much in the long-standing tradition of health administration and management, albeit now recast as general management and subject to more businesslike approaches following implementation

of the Griffiths Inquiry and the *Working for Patients* reforms. Secondly, there was now a purchaser management community (New Public Management's 'steerers'), that was significantly more developed than it had been a decade earlier. It comprised two strands: the one focused on health authorities (and incorporating the former family health services authorities and district health authorities), and the other on the many and varied primary care purchasing organisations that had been allowed to flourish under the Major government and which had grown partly out of the management of general practices themselves. It was into this health management context that a Labour government was elected in May 1997.

It is interesting to compare these two health management communities, both in 1997 and now. The provider group is concerned with the organisation and leadership of physical entities (e.g. hospitals, mental health organisations), hence with the management of institutions. On the other hand, the purchaser group relates to the management of less tangible functions such as health planning, funding and purchasing, and includes responsibility for contracting with diverse general practices and other primary care providers. From 2002 onwards, as is explained below, primary care trusts (successors to health authorities) assumed management responsibility for community health services along with their purchasing role, but this continued the trend for the purchaser management community to be largely concerned with the running of dispersed and networked (as opposed to tangible institutions) organisations.

In the interviews for this research, it was striking that trust chief executives were based in offices on the main hospital or mental health provider site, whereas PCT

(purchaser) chief executives were typically located in office blocks within a suburb of a town, or in units on industrial estates on the periphery of cities. This appeared to underline the difference in nature of the two health management communities that have evolved in the NHS, communities that have their roots in political decisions taken at the time of formation of the NHS.

A new concern for equal opportunities

A further policy development during the 1990s that is of relevance to the research reported in this thesis was a growing concern about the lack of representation of women within senior management in the NHS. In 1986, the Equal Opportunities Commission (EOC) highlighted the issue of equal opportunities for women within the NHS when the chair of the EOC raised her concern with the Minister of Health. The chair of the EOC suggested that a career break scheme be introduced into the NHS and this resulted in the establishment of the National Steering Group on Equal Opportunities for Women in the NHS (Redmond, 1993). The group's terms of reference were broadened to include issues associated with an overall policy on equal opportunities for women in the NHS. When the group reported, it recommended an agenda of action for NHS management and produced a handbook for developing and implementing equal opportunities. The rationale for this was set out as being: men were more likely to be able to earn higher incomes than women; despite more women than men working in the NHS, women had less chance of gaining promotion (only 17.3% unit general managers in 1987 were women); and the working pattern in the NHS expected people to work full-time with any break in employment, and women who were unable to do this lost out.

In 1991, the EOC produced a report into women in the NHS, highlighting major concerns about the employment of women in the health sector (Equal Opportunities Commission, 1991). This concern included the poor representation of women in senior management and limited training and promotion opportunities for women. This report confirmed research by Davies and Rosser in respect of over-representation of women in lower levels of NHS organisation (see chapter 3 literature review). It also highlighted what it claimed to be a dominant belief in the NHS that women were not really interested in promotion, and also a lack of part-time work and flexible working arrangements. The EOC review made recommendations that included that the NHS Management Executive should set national targets to increase the number of women in senior management posts, arguing that there were economic, as well as social justice reasons for this.

Societal and governmental concern about the lack of women in senior management posts across public and private sectors was expressed in the aspirations of the Conservative Government's Opportunity 2000 initiative (Business in the Community in the UK, 1991). Opportunity 2000 sought to increase the numbers of women in all areas of public life. The NHS formally espoused the policy in 1992 (NHS Management Executive, 1992) and set up a Women's Unit to lead the implementation of targets concerned with increasing female participation in roles such as chief executive, nurse director, non-executive director and chair. In this way, the NHS was apparently seeking to do what Myerson and Kolb (2000) called 'fix the women' (see chapter 3 literature review), given that much of the action proposed by the Women's Unit was focused on support and development aimed at enabling women to compete on a more level playing field with men in seeking senior management posts. As will

be explored later in this thesis, the NHS Women's Unit represented a specific policy initiative aimed at changing the demography of NHS management.

The NHS in the twenty-first century: central planning and a desire to devolve

The NHS under New Labour

The Blair government elected in 1997 was clear from the outset that in relation to public policy, it wished to seek a 'third way' between 'Old Labour command and control' and the internal market approach of the Conservatives (Ham, 2004). Public spending on health was constrained by a commitment to stick to the Conservative Government's health spending plans, and the policy of using private finance to fund capital projects in the NHS was also carried forward. The overarching health policy of the Blair government was set out in a white paper in December 1997 *The New NHS. Modern. Dependable* (Department of Health, 1997). This made it clear that the new government was committed to retaining the purchaser-provider split within the NHS, albeit that it was asserted that there would be more of a focus on planning and collaboration rather than competition. GP fundholding was to be abolished and replaced by local commissioning bodies called primary care groups. These primary care groups were to operate initially as part of health authorities and then, over time, assume additional commissioning and funding responsibilities as primary care trusts, also taking responsibility for the provision of community health services. The white paper also introduced into NHS policy the concept of 'clinical governance' and signalled that NHS chief executives would be made responsible not only for financial performance as in the past, but also for the clinical governance and quality standards of their organisation.

The NHS Plan

As self-imposed spending constraints in the NHS began to bite, the Labour government faced criticism about underfunding and lack of service capacity, especially in relation to people's ability to access elective and outpatient services. In 2000, Tony Blair announced that he was committing the government to raising health expenditure as a proportion of gross domestic product to the level of the European average, and this was then formally announced in the 2000 Budget (Ham, 2004).

The money was not however to be given to the NHS without strings attached. The strings came in the form of the *NHS Plan* published in 2000 (Department of Health, 2000). This plan proposed a wide range of measures and targets intended to 'modernise' the NHS. There was a strong focus on improving access to services for individual patients, especially in relation to waiting lists and times, and on extending the choice of provider. A new performance management system was outlined, based on a concept of 'earned autonomy' whereby high-performing organisations would be allowed greater spending freedoms and be subject to less close performance monitoring. There were other commitments relating to workforce, facilities and public health. However, the overriding impression was of a plan for improving access and choice in the NHS, supported by a regime of targets, incentives and sanctions. This was largely a health *service* plan rather than a public health plan, clearly located in a patient, rather than population paradigm. Some critics of the *NHS Plan* saw it as ushering in more radical marketisation of the NHS (e.g. Pollock, 2004), whilst others (e.g. Hunter, 2001) focused their criticism on its central focus on hospitals and secondary care services, scant attention to public health and inequalities, and apparent

lack of attention to how radical change would actually be brought about within the NHS.

Shifting the Balance of Power

The year following publication of the NHS Plan saw the government issuing a policy paper *Shifting the Balance of Power* (Department of Health, 2001) which set out organisational and governance reforms designed to devolve decision-making closer to ‘the frontline’ of staff and patients. This represented a significant upheaval for the primary care and commissioning management and organisational community, for which it was criticised as being a form of ‘redisorganisation’ (Smith et al, 2001; Walshe and Smith, 2001) that would compromise the ability of purchasing organisations by forcing them to focus their efforts on incentivising providers to ‘modernise’ and seek to achieve the targets set out in the *NHS Plan*. The paper signalled the abolition of the 100 health authorities, the establishment of 28 strategic health authorities, the moving of all primary care groups to PCT status (all of these developments were to take place in April 2002), and an extension of the remit of PCTs to include all commissioning of health services for local people, management of all community health services, those public health responsibilities previously held by health authorities, and partnership working with local authorities and other agencies. *Shifting the Balance of Power* lent a sense of urgency to the implementation of the *NHS Plan*, ending the evolutionary track for PCGs and PCTs set out in the 1997 White Paper (the ten-year plan had become a three-year programme of compulsory change), redrawing the organisational landscape of NHS commissioning, and establishing PCTs as the key local health funding and purchasing organisations for a community (Dowling and Glendining, 2003; Smith and Goodwin, 2006).

NHS foundation trusts

Provider organisations were not immune from organisational change during this period. Like health authorities and PCTs, provider organisations fell under the scrutiny of health secretary Alan Milburn who was (so he alleged, despite critics pointing to the centralist nature of the *NHS Plan*, its associated targets, and the *Shifting the Balance of Power* reorganisation) seeking a move away from ‘command and control’ management towards a more devolved and locally governed system. In 2002, the government announced a proposal for the establishment of ‘NHS foundation trusts’, which were to be organisations with a new form of governance intended to allow a greater degree of local autonomy and flexibility, being outside of central NHS management, accounting instead to a board of local governors, and being regulated by Monitor, a new regulator established in order to approve applications for and then to hold to account, foundation trusts. Day and Klein (2005) described the presenting problems faced by the government in 2002 as follows:

‘Managerially, it [the command and control approach] stifled initiative: NHS managers were loud in their denunciation of central government target-setting, performance monitoring and intervention in the day-to-day running of services. [...] The logic of such a [foundation trust] system was to give providers freedom from central control; to make a reality of what the Conservative Government had sought to do but failed to carry through in practice, when introducing the internal market in 1991 – i.e. to give provider trusts a real degree of autonomy in financial and other respects. Enter foundation trusts.’ (Day and Klein, 2005, p7)

The government faced significant opposition in getting legislation relating to foundation trusts through parliament, but eventually the Health and Social Care Act (Community and Health Standards) 2003 was passed, enacting foundation hospitals, the first of which were established in April 2004 as public benefit corporations.

Commissioning a Patient-Led NHS

Shifting the Balance of Power was not the last word in NHS reorganisation of the commissioning (purchasing) function within the time of the Blair government. In July 2005, the government published *Commissioning a Patient-Led NHS* (Department of Health, 2005a) which signalled a reduction in the number of PCTs with effect from October 2006, along with a smaller number of strategic health authorities. It also suggested that PCTs should increasingly concentrate on their role as commissioners and should explore ways in which they might divest themselves of their provider functions. What this policy meant in reality was another major NHS reorganisation of purchaser organisations along with the attendant disruption that is inevitable at such times of imposed organisational restructuring (Dickinson et al, 2006).

Central planning or a move towards devolution?

During the years of Conservative government, it was clear that an internal market for the NHS was the centre-piece of health policy. Under the Blair government, the initial ‘third way’ with its suggestion of steering a course between markets on the one hand and central state control on the other seemed over time to give way to an approach that was more focused on market mechanisms, and arguably more so than the Conservative approach of the 1990s. Similarly, the central-control approach to health policy implementation used in the early years of the Blair government (national targets backed up with a range of sanctions for poor performance) gradually ceded to one where there was more emphasis on the use of levers such as patient choice and the involvement of local people in the governance of foundation trusts. Indeed, Alan Milburn expressly set out his desire to move the service away from ‘command and

control' in announcing *Shifting the Balance of Power* and later the introduction of NHS foundation trusts.

Labour policy since 1997 has apparently been concerned with developing an external market in the NHS, with its focus on stronger commissioning (purchasing) organisations, the development of more autonomous providers, the creation of more choice for patients, and other developments such as explicit encouragement of private providers into the market for diagnostic, elective and primary care services (Lewis et al, forthcoming; Ham, 2008). Health funding in England increased by more than twofold in the early years of the twenty-first century. However, health organisations and managers in England faced tough requirements in return for this, in relation to national targets, sanctions for not achieving such targets, and accountability that was extended to cover clinical and well as financial performance.

Chapter summary

For NHS managers these have been tumultuous and difficult times. From the relatively hasty and ideologically-driven introduction of general management, through the implementation of the NHS market and establishment of a purchaser-provider split in the management community along with GP purchasers, to the 'modernisation' of the NHS through expanded funding and multiple national performance targets, managers have been expected to 'step up to the plate' and deliver the aims and objectives of the government of the day.

In the next chapter, attention will focus on seeking to understand the demography of the management population over this period, to consider its gendered nature, and

examine ways in which accounts of career can be ‘stories of self’. This will be a prelude to hearing stories of what it is to be a senior manager in the NHS and charged with implementing policy developed by political masters whose responsibility is to try and secure maximum benefit from a universal and publicly funded health system that is inherently political in its nature (Berwick, 2008).

CHAPTER 3

LITERATURE REVIEW

Introduction

This chapter explores the academic and policy literature related to the core questions of this research study. The chapter seeks to: locate this PhD research within a wider body of literature; identify the studies, theories and concepts of most relevance to the questions being asked in this study; and develop a literature-based conceptual framework within which to analyse and report the project's findings. The review is necessarily selective in its nature, and focuses on those themes most salient to the core analysis within the research. Three bodies of literature are examined:

- i) the demography of health services management in the National Health Service (NHS);
- ii) gender in organisational life; and
- iii) the storytelling of career and self.

This chapter is structured around these three main bodies of literature, and seeks to contextualise the overall analysis presented within this thesis. Literature related to other areas in which the composition of the NHS senior management population is less than representative, for example concerning race and disability, has not been explored within this research. An explicit decision was made to focus on the issue of gender and senior health services management, both in order to do justice to a single

strand of ‘difference’ within the chief executive population, and to avoid superficial analysis of other important dimensions of the NHS leadership population.

The demography of health services management in the NHS

This research sought to map the population of chief executives in the NHS in England in 2003 and 2006, and to use these data as the basis for subsequent analysis of a specific sub-group of the population, namely women chief executives. Similar mapping studies were carried out in the 1980s and 1990s and provided inspiration for the undertaking of additional mapping by this research in the 2000s.

Studies mapping the NHS chief executive population in the 1980s

In the 1980s, studies of management in the NHS were concerned with answering the question ‘who are the general managers in the NHS?’ in order to explore the impact of the implementation of the Griffiths Inquiry into health services management (see chapter 2, policy context). A study of newly appointed unit general managers (UGMs) (Disken et al, 1987) revealed that whilst a majority of UGMs came from an administrative background, over 10 % were from a medical background and a similar proportion had had a career in nursing. Just less than ten per cent of UGMs were recruited from outside the NHS, mainly from the private sector and the armed forces. In relation to gender, 82.7% UGMs were men and 17.3% were women. The Disken et al study also found an association between the gender of managers and type of service unit managed. For example, only 11.7% acute unit managers were women. Types of unit with an above average proportion of women were maternity, community and what was then termed priority care (mental illness or learning disability services).

The introduction of general management in the NHS led not only to demographic studies but also to research that sought to examine the roles performed by general managers, and to compare them with the administrators whom they had replaced. One example of such work was that led by Rosemary Stewart. This focused first of all on the role of district administrators (Stewart et al, 1980) and then, following the Griffiths Inquiry, the Templeton series of studies (Dopson et al, 1987, a-e) of the role of the district general manager (the new cadre of managers leading those authorities post-implementation of Griffiths). In their initial study of district administrators, Stewart and colleagues explored the demands, constraints and choices placed upon these managers and identified five main roles associated with the district administrator post: administrator, linkman (sic), shaper, innovator and general manager (Stewart et al, 1980). They noted that district administrators had specific development needs in relation to improving 'supervisory relations', and being enabled to work towards more interdependent relationships.

Follow-on research by Dopson and Stewart traced the role of new district general managers (DGMs) according to various dimensions including: managing with doctors (Dopson et al, 1987a), working with chairmen (sic) (Dopson et al, 1987b), the relationship between districts and units (Dopson et al, 1987c), the process of learning to be a DGM (Dopson et al, 1987d) and an overview of the role (Dopson et al, 1987e). What is striking from Stewart and Dopson's work on district administrator and general manager roles is that issues such as 'supervisory relations', 'interdependent relationships' and 'managing with doctors' resonate strongly across both the district administrator and DGM roles, suggesting that at least initially, there was not a

significant change in the day-to-day work of managers at the most senior local level in the NHS.

A national graduate training scheme for the NHS was established in 1956, and has, over many years, been widely viewed as an important route to becoming a senior NHS manager (Stewart and Smith, 1982; Ryan, 2001; Saunders 2006). In 1983, Smith and Stewart reported on a study of the National Administrative Training Scheme (NATS), highlighting that despite a gradual increase in the proportion of women trainees over the years, this was not being matched by a parallel evening out of the gender split at senior management levels in the NHS. They noted that in 1979, of the top 269 administrators in the NHS, only three were women, and at the next level - 'senior' - only 15 of 351 were women. When the NATS started in 1956, there were two female women entrants out of 14, and until the mid-1960s, there continued to be only one or two women per intake. By the early 1980s however, there were over 50% female trainees.

Attrition of scheme graduates had been higher for women than men, but this study (Smith and Stewart, 1983) focused on the career paths of those remaining in the NHS. The study found that all but one of the women who had been on the NATS scheme were in junior or middle grade posts, with the difference in progress by women being marked even where a more recent cohort had a sizeable proportion of women. Reasons cited by Smith and Stewart as a possible cause of the poorer career progress for women ex-trainees were: career breaks (although few had had these); being less interested in promotion (although no evidence was found of this); women being less good at marketing themselves (the study was unable to ascertain if this had been a

reason); or that selection panels preferred male candidates, seeing them as a better prospect in relation to continuity (the study implied this to be a reason contributing to women's limited progress to senior ranks and called for more research). It was noted (in a prefiguring of Disken et al's findings in 1987) that:

‘women get fewer opportunities for jobs in major acute hospitals, which are seen as a necessary stepping stone in a career’ (Smith and Stewart, 1983, p320).

This analysis in the 1980s of NHS administrative trainees likewise prefigures the findings of the 1990s' Creative Careers Paths studies in relation to the challenges facing women in 'breaking through' to the senior levels of NHS management in a similar proportion to their male colleagues. It also supports the evidence from Disken et al (1987) of the tendency of women to work as senior managers in non-acute health care organisations.

In 1986, Dixon and Shaw reported on a study of NHS administrative or management trainees known to have left the NHS. They sought to examine the career paths of this cohort and to examine their reasons for having left NHS employment. The research expanded upon and explored the concern about gender that was set out in Smith and Stewart's work three years earlier. The analysis made by Dixon and Shaw of the needs people expressed in a job, and of sources of dissatisfaction with the NHS, led to consistent findings for both men and women, and no significant gender difference. In other areas however, such as flexible and part-time working, rate of progression through the service, and likelihood of leaving the NHS at an early stage, there was a clear difference in terms of the priorities and experience of men and women. For example, women were more likely to cite factors such as lack of flexible and part-

time working as a reason for leaving the NHS. The report concluded that the NHS was failing too many ex-trainees, and in particular women, mainly because of an inability to accommodate flexible working related to childcare responsibilities. Thus, the study regarded the issue of gender in the NHS as being one where there was a need to ‘create equal opportunity’ (after Myerson and Kolb, 2000 – see discussion later in this chapter). This theme was later picked up and explored further in the Creative Career Paths studies (IHSM Consultants, 1994) as reported below.

Studies mapping the NHS chief executive population in the 1990s

In the early 1990s, the NHS Women’s Unit commissioned an extensive empirical ‘Creative Career Paths’ study that sought to map the career paths of what they called ‘top managers’ in the NHS. The intention was to map who senior managers were, and to find out more about the work and personal circumstances and what these factors meant in relation to career progress, with a particular interest in the respective situations of male and female managers. The top manager element of this project entailed a survey of 894 senior managers in the NHS in the UK and concluded that:

‘The ‘typical’ top manager in the NHS is a 46 year old, white man. He is married with 2 children over 15 years old. He has a Bachelors degree and the IHSM qualification and earns a salary in the £50,000 to £59,000 per annum range which comprises more than 90% of the household income’ (IHSM consultants, 1994a, p11).

The final report that drew together findings from the series of Creative Career Path studies and set out an agenda for action (Caines and Hammond, 1996) made the following observation:

‘There is mounting evidence that traditional managerial career paths in the NHS are increasingly out of tune with the current and future needs of NHS organisations and of many potential and future NHS managers. Rigidity in career and working patterns limits those with family and other domestic commitments and those who do not fit the stereotypical image of the successful manager... (Caines and Hammond, 1996, p27)

The Creative Career Paths studies represent a major mapping of the NHS management community in the mid-1990s, a decade after the introduction of general management and Disken et al’s study of the UGM population of the mid-late 1980s. They reveal a picture of NHS senior management as a largely male, middle-aged and white preserve, with those women who were at chief executive level being much more likely than men to be unmarried and not to have children. Interestingly, despite relatively stark findings of gender inequity in NHS senior management, the Creative Career Paths studies, like Disken et al before them, appear to call for ‘fix the women’ or ‘create equal opportunity’ solutions (Myerson and Kolb, 2000), rather than mounting a fundamental challenge to the dominant discourse of NHS leadership and senior management. In other words, in the 1980s and 1990s, analysts of gender and organisation in the NHS appeared to want to find ways of enabling women to compete on equal terms with men, or to be supported in gaining senior posts, in preference to any significant questioning of the expectations and content of senior leadership roles.

It is noteworthy that there appear to have been fewer studies of the demography of NHS senior managers or chief executives in the late 1990s and early 2000s, both in relation to the chief executive role and the demography of the NHS chief executive population. The research reported in this thesis is intended as an update to the demographic picture painted by Disken et al and the Creative Career Paths studies in the 1980s and 1990s respectively.

Studies of managers of primary care organisations

Most studies of senior health services managers in the UK in the 1980s and 1990s were concerned with chief executives of hospitals, mental health service providers, community service providers, and health authorities. Some studies (e.g. the Creative Career Paths top managers' survey) also covered the managers of regional health service bodies, ambulance service organisations and the managers of family health services authorities (FHSAs).

In the 1980s, research into the management of family practitioner committees (FPCs), the bodies that administered general practice, community pharmacy, opticians' and dental services (see chapter 2 policy context for more detail), was carried out by Allsop and May (1986). This research revealed FPC administrators (the most senior manager in an FPC) to be a relatively isolated figure charged with overseeing the administration of local primary care services whose contracts were held by central government. Interestingly, Allsop and May make no comment at all about the background or demography of the FPC administrator population.

In 1987, the King's Fund published a report (Huntington et al, 1987) on the training and development needs of FPCs. As with Allsop and May, the study is silent in relation to the demography of the senior manager (FPC administrator) population, no comment being made about gender or other features. Huntington et al (1987) called for a shift from an administered to a managed primary care service, and pointed to a need for 'a cadre of administrators who could give leadership not only to their own FPCs, but to the FPS world in general...' (Huntington et al. p53). In this way, the

report was prefiguring the establishment of family health services authorities (FHSAs) in 1991 and the implementation of a more proactive model of general management in the primary care sector, mirroring the earlier implementation of general management into other sectors of the NHS in the mid-1980s (see chapter 2). By 1991, FHSAs were led by general managers, the managerial successors to FPC administrators in much the same way as unit general managers were considered to be the ‘new wave’ of managers to replace hospital administrators in the mid-1980s.

In addition to FHSAs, the other category of primary care organisations to emerge in the NHS in the 1990s was the GP-led purchasing or commissioning organisation, as is explored in more detail in chapter 2 (policy context). The managers of these new organisations, whilst not having been the subject of a specific study, however, have been considered within evaluation projects examining the implementation and development of new NHS primary care organisation over the period 1995-2005. Such studies revealed a strong desire on the part of the GPs and health authorities to find appropriate levels of management support for their new organisations.

In the national evaluation of one set of new primary care organisations, the total purchasing projects (TPPs), Mays et al (2001) reported a statistically significant relationship between the level of management support allocated to a TPP and its ability to achieve its project objectives. In setting out lessons from the TPP experiment, Wyke et al (2001, p90) highlighted the importance of ‘key, able leaders’, whilst also noting that:

‘The most productive TPPs had a virtuous combination of strong leadership and the inclusion of a range of other key players and stakeholders willing to play an active role in the organization’ (Wyke et al, in Mays et al 2001, p91).

In this way, we see the 1980s NHS general management themes of stakeholder relationship management and working with doctors recurring in the 1990s experience of primary care organisations.

National studies of primary care groups and trusts (e.g. Regen et al, 1999; Smith et al, 2000; Regen et al, 2001; Wilkin et al, 2000, 2001 and 2002) consistently commented on the extent to which lack of management capacity tended to be a barrier to overall progress, and on the destabilising impact of primary care organisations facing regular policy change, such as the move from commissioning pilots to PCGs, followed by a forced move from PCG to PCT status.

Smith et al (2000) noted that a majority of PCG chief executives came from a health authority background, having worked as senior or middle managers in primary care or commissioning. An Audit Commission report of PCG implementation (Audit Commission, 1999) set out the background of PCG chief executives appointed by February 1999, noting that the majority (61%) had been health authority employees, 12 per cent employed in general practice, 11 per cent by a community trust, 11 per cent elsewhere in the NHS, and 5 per cent coming from outside the NHS. In concluding this report, the Audit Commission noted that with the impending move of many PCGs to PCT status, PCTs would require a different range of management skills to PCGs. These studies did not however explore the demography of this new cadre of senior managers in the NHS, beyond finding out their prior post. It can be argued that researchers of new primary care organisations were complicit in the

‘disappearance of gender’ (Fletcher, 1999) when examining the nature of the leadership population in the NHS, failing to take the opportunity presented by major evaluation studies to consider gender (in)equity and to explore the demography of the chief executive population.

From the research that was carried out on the management of primary care organisations, areas of similarity with NHS trust management were revealed (e.g. working with clinicians, handling multiple relationships) and also difference (e.g. being isolated as senior managers with few peers, working in new and evolving organisations, accommodating regular structural upheaval, having few organisational or institutional resources in the early days). As noted in chapter 2 (policy context), the management of purchasing and primary care in the NHS had two main origins: one associated with statutory administration and management of primary care (executive councils, FPCs, FHSAs, and health authorities) and the other related to GP-led purchasing organisations.

Summary: the demography of health services management in the NHS

This examination of the literature exploring the demography of health services management in the NHS reveals the extent to which the population of senior managers in the 1980s and 1990s was overwhelmingly male, and with senior women managers being more likely to occupy posts in non-acute (community or mental health services) organisations. This raises questions about gender equity, and the structural and cultural barriers that appear to confine women to a minority of roles within certain (arguably less glamorous) areas of health management. For example, issues for exploration might include: the reasons why women appear to eschew (or

not be encouraged to apply for) acute hospital management posts; the extent of discrimination within recruitment to acute hospital management; the experience of women who become chief executives; the impact of specific structural initiatives such as the development of an NHS Women's Unit in the 1990s; and whether other equal opportunity initiatives, or a more radical challenge to the model of NHS leadership, are required if a focus on addressing gender inequity in senior health services management is a serious concern in the NHS. In the next section, an exploration is made of the gendered nature of organisational life and leadership, in an attempt to provide context to the exploration of the experiences of women chief executives within this research.

Gender in organisational life

This section explores the literature related to gender in organisational life. The themes considered include: gender and organisation; gender and power; gender in NHS management; and the performativity of gender.

Gender and organisation

In the 1960s and 1970s, feminist and other critical accounts of women's and men's positions in society drew attention to what they considered to be an important distinction between sex and gender (Broadbridge and Hearn, 2008) – for example, Oakley (1972) wrote about distinguishing biological sex differences (sex) from socio-cultural constructions of sex differences (gender). Broadbridge and Hearn assert that:

‘the sex-gender model has prompted path-breaking work on gender relations, some attending to attitudes, self-concepts and identity, others focusing on social categories and structural relations’. (Broadbridge and Hearn, 2008, pS39)

The importance of incorporating gender into an understanding of management and organisation started to gain currency in the late 1970s. There were two dominant sets of literature at this time – studies of gendered labour markets, and writings on ‘women in management’ (Broadbridge and Hearn, 2008). The field was regarded as being opened up by Rosabeth Moss Kanter’s work on the relative position of men and women within organisations (Kanter 1975, 1977). Kanter set out an extended case study of a large US corporation in ‘Men and Women of the Corporation’ (1977). She drew attention to the gendered nature of bureaucracy and management, although she stopped short of presenting a gendered account of power in the workplace.

Kanter’s research asserted that work attitudes and behaviour were a function of the location of a person within organisational structures and not a function of sex differences. In this way, she was holding back from directly asserting any particular differences in how men and women function in the workplace, calling instead for attention to be paid to how organisations operated in relation to issues such as structuring of jobs, opportunities for training and development, processes for promotion, and was shifting the onus onto organisations themselves in respect of accounting for the relative progress of men and women and explaining gender differences in terms of roles, promotion, pay and so forth. Hearn and Parkin explain Kanter’s position as follows:

‘Men, as well as women, are in disadvantaged positions both in society and in organizations, but women are more. It is the structure of the power within an organization which explains the concentration of women at the bottom rather than gender attributes or characteristics’ (Hearn and Parkin, 1983, p230).

By the 1980s, work on gender and organisation tended to focus on gender divisions of labour and gender divisions of authority and hierarchy. This was evidenced in a review of the literature on gender and organisation in 1983, where Hearn and Parkin took as their starting point the fact that:

‘most organisations remain patriarchal, if only by virtue of their domination by men. There are very few, if any, organisations composed of more men than women, yet managed by women’ (Hearn and Parkin, 1983, p220).

These authors asserted that organisational theory had to date largely neglected issues of sex and gender, concluding that there was value to be gained from taking a feminist approach to examining gender and organisation, although the methodological issues were significant:

‘until the most discriminated against can themselves research and theorize, or at least have their concerns brought more centrally into organization theory’ (op cit, p234)

An author whose work was influential in drawing attention to the gendered nature of organisations was Acker (1992) who highlighted the gendered nature of particular functions and structures in organisations and workplaces, and connected this to issues of equity, disadvantage and organisational practice. She claimed that:

‘advantages and disadvantages, exploitation and control, action and emotion, meaning and identities are patterned through, and in terms of distinctions between what is constructed as male and female, masculine and feminine’ (Acker, 1990, p146).

Acker identified five ‘gendering processes’ that she regarded as the source of the problem in respect of gender inequity in the workplace, these being: formal practices

and policies (that appear neutral but have a differential impact on men and women); informal work practices (that appear neutral but again have a differential impact on men and women); organisational symbols and images (that often express and legitimate gendered divisions in the organisation); everyday social interactions (that enact patterns of domination and submission between men and women); and people's internalisation and expression of their gender identity (what it means to look, act, and talk like a man or woman).

Acker (1992) also analysed the gendered nature of the professions, particularly in respect of medicine and nursing, asserting that the male or female tag of the professional group influences the status and confidence of its members. Celia Davies (1995) took forward this analysis of the gendered nature of the professions, exploring the 'cultural codes of gender' within health professions, asserting that different kinds of management (e.g. in nursing as opposed to general management) were reinforced by these gendered codes.

Myerson and Kolb (2000) in a paper entitled 'Moving out of the armchair' sought to extend Acker's work by viewing the five gendering processes as 'sites for resistance and change' rather than merely the source of the problem faced by women seeking gender equity in the workplace (in so doing, they appeared to challenge Acker's work for not going beyond description of the problem into a more fundamental challenge about addressing gender inequity). This led to Myerson and Kolb proposing four frames to use when seeking to understand gender within organisations:

- i) equip or fix the woman (for example, programmes to enable women to compete as equals of men);
- ii) create equal opportunity (for example, try and eliminate procedural and structural barriers to women's advancement);
- iii) value difference (for example, view the route to equity as one of recognising and celebrating differences); and
- iv) resist and revise the dominant discourse (start from the premise that organisations are fundamentally gendered and largely created for men).

This analysis sought to use feminist theory to advance and implement gender equity in the workplace and was based on a large action research project in a major US corporation. Myerson and Kolb argued that organisations needed to 'change from the fourth frame', drawing on some or all of the other three frames, but striving to keep the gender equity perspective alive alongside business imperatives, to avoid what Fletcher (1999) called the issue of 'losing gender'. Myerson and Kolb suggested that change from the fourth frame needed three stages: critique of the status quo in relation to inequity (how gendering processes produce inequities in the organisation); experimentation with changes that have the potential to interrupt gendering processes and also improve work effectiveness (seeking to engage organisational players in developing practical actions); and the development of narratives (because experiments will not speak for themselves, and stories need to be constructed to make sense of gender equity and organisational effectiveness).

The analysis by Myerson and Kolb echoes some of the history of NHS policy and practice in relation to gender inequity in the past two decades. The studies of women in the NHS carried out in the late 1980s and early 1990s and the subsequent creation of the NHS Women's Unit (see chapter 2 policy context) appear to have been attempts to 'fix the women'. Following that, a focus on equal opportunities (the Women's Unit became an Equal Opportunities Unit) along with initiatives aimed at improving childcare and similar provision (e.g. The Improving Working Lives policy [Department of Health, 2000b]) could be considered as 'create equal opportunity', as could the Gender Equality Duty referred to below. How far the NHS has espoused the 'valuing difference' frame is harder to say, but a sense that gender has been 'lost' (after Fletcher, 1999) is apparent from the policy analysis carried out as part of this literature review, and hence it could be argued that attention to the fourth frame of resisting and revising the dominant discourse of a gendered organisation is required, an issue that will be returned to in chapter 7 (discussion).

That gender continues to feature as a dimension of inequality is evident in the publication of a 'Gender Equality Duty' by the UK Department of Health in 2007 (Department of Health, 2007) that places a legal responsibility on public authorities to promote equality of opportunity between men and women. Policy such as this reflects the fact that while women now occupy 34.5% managerial positions compared with just 2% in 1974 (Equal Opportunities Commission, 2006), men continue to be in the majority within management, and research points to this being particularly the case in senior, policy-making positions (e.g. Singh and Vinnicombe, 2004, 2005, 2006). Despite women having high levels of education and an expressed desire to make

progress in their careers, male managers are more likely to be better paid than women managers, to be in more secure employment, to be on higher grades, and to not have experienced discrimination or prejudice (e.g. Chenevert and Tremblay, 2002; Calas and Smircich, 2006, Gatrell and Cooper, 2007).

For some commentators, gender equality is related to a concern for social justice, as set out in *The Gender Agenda*:

‘Tackling [gender inequality] would make sense for our social health and financial wealth, as well as bringing justice...’ (Equal Opportunities Commission, 2007, p3)

Similarly, researchers into gender and organisation often use the term ‘gender inequity’ to refer to the disproportionate representation of women within organisations, occupational groupings, and levels of workplace hierarchies (e.g. Myerson and Kolb, 2000; Myerson and Fletcher, 2000; Ngo et al, 2003).

For others it is about ‘business sense’ or ‘organisational effectiveness’ as set out by Schwartz (1987, 1988) who asserted that supporting talented women’s career aspirations was critical in making sure there was as wide a pool as possible to draw from when selecting leaders in organisations. Myerson and Kolb (2000, p555) referred to this two-pronged argument about equity and effectiveness as the ‘dual agenda’, and suggested there was value to be gained by organisations in seeking to approach organisational change and development with both the advancement of gender equity and improvement in organisational effectiveness as core objectives.

A further argument put forward for increasing the proportion of women in leadership positions is related to the enabling of a more diverse culture within organisations, where a belief is held that women to some extent 'lead differently' as asserted by Rosener (1990) who claimed, based on research she had carried out into leadership in the USA, that women practised 'interactive leadership', encouraging participation, sharing power and information, making people feel important and energising them. This argument can be seen to be concerned with 'valuing difference' as per Myerson and Kolb's 'third frame'. Rosener's work has been influential in part due to her alignment of women's alleged 'interactive' style of management with 'transformational' leadership, and this seems to affirm that women are in some way particularly suitable for management. The work has however been criticised for the risk it runs of 'recreating old stereotypes of women as caring and relational, and as fitted to jobs in new female ghettos' (Marshall, 1995, p16). Similarly, Calas and Smircich (1993) point to the danger of identifying women with certain roles within organisations that are likely to be characterised by lower pay and status, leaving strategic international management posts associated with 'male' qualities.

The 'transformational' leadership referred to by Rosener reflects a distinction first made by Burns (1978) and later refined by Bass (1985), and one that has been summed up by Alimo-Metcalfe (1998) as follows:

'Leadership has experienced a major reinterpretation from representing an authority relationship (now referred to as management or Transactional Leadership which may or may not involve some form of pushing or coercion) to a process of influencing followers or staff for whom one is responsible, by inspiring them, or pulling them towards the vision of some future state...this new model of leadership is referred to as Transformational Leadership because such individuals transform followers.' (Alimo-Metcalfe, 1998, p7)

Whilst Alimo-Metcalfe presents this as a simple dichotomy, Peck (2006) suggests this to be misguided, calling instead for a judicious mix of transactional and transformational elements to be included within the performance of effective leadership, given that management tasks and attributes are required *as well as* and not instead of a degree of inspirational and relational leadership. Nevertheless, this dichotomy has been influential within leadership and management literature, and as with the work of Rosener (1990), has at times been used in order to differentiate ‘masculinised’ (i.e. transactional) and ‘feminised’ (i.e. transformational) approaches.

Broadbridge and Hearn (2008) assert that since the 1990s, trends in gender and organisation have included growing attention to the gendering of men in organisations and management. For example, in 1994, Collinson and Hearn highlighted how men and masculinities were frequently central to organisational analysis, yet rarely the focus of study. They identified five ‘masculinities’ that they deemed to be pervasive and privileged within organisations and management, and explored how these masculinities were reproduced in a subjective search to identify self. The five masculinities were: authoritarianism; paternalism; entrepreneurialism; informalism; and careerism. These authors called for more research that would ‘critically examine the conditions, processes and consequences through which the power and status of men and masculinities are reproduced within organizational and managerial practices’ (op cit, p18). The linking by Collinson and Hearn of gender and self drew on the work of Kondo (1990) who highlighted the ambiguous and contradictory nature of gendered selves and identities in organisations, a theme that is central to the analysis carried out in this research (see below for more discussion of Kondo’s work).

Gender and power

The relationship between gender and power within organisations was underlined by Korda (1976) who asserted that power was essentially thought of as ‘male’ within organisations. Spender (1982) similarly set out how women’s attempts to contribute their definitions of reality to the pool of knowledge about organisations often find themselves lacking legitimacy or being undermined. Hearn and Parkin drew on Korda’s analysis to assert that ‘Not only do men dominate within organizations, but they dominate the currency by which domination is maintained’ (op cit, p230). Similarly, they outlined their belief that sexual stereotypes constituted a significant part of organisational reality and served to constrain women into certain roles at work – this is a theme that was further developed in Alimo-Metcalfe’s work in sex-role stereotypes in the late 1980s and early 1990s.

That gender-organisation stereotypes might exist between as well as within organisations was highlighted by Mennerick in 1975 in a study that showed how women tended to enter less prestigious organisations, even within non-stereotyped sectors of work. This echoes across the decades as studies of health services management in the 1980s and 1990s reported earlier in this chapter and the surveys carried out for this research in 2003 and 2006 demonstrate that women persist in their tendency to become chief executives of non-acute or purchasing (rather than hospital) organisations, despite an overall increase in women reaching chief executive posts.

Others have explored the issue of power and gender in relation to enabling women’s voices to be heard within organisations and research, and ‘to name and interpret their own experiences’ (Marshall, 1995, p17). Marshall drew on work such as Mills (1991)

about the gendered nature of communication at work, and (West and Zimmerman, 1991) about the 'doing' of gender to assert that gender inequalities may covertly shape behaviour within organisations.

An additional strand of writing about gender and power within organisations asserts that successful women align themselves with prevailing organisational values and power structures and thus become 'prisoners of men's dreams' (Gordon, 1991). This arguably leads to what Marshall (1995) calls a toughening of organisational cultures and makes the transformation of employment towards something more humanistic and caring less likely.

What is clear is that an analysis of power in organisations can assist with understanding the relative position of women and men within organisational hierarchies, and also in relation to issues such as pay and promotion. Evidence of persisting inequality in women's access to senior posts within organisations might be explained by an analysis of power and gender, and points to why many commentators continue to see the issue of women in senior management as concerned with social justice and gender equity, often alongside arguments about business sense and organisational effectiveness.

Gender and NHS management

Early analyses of gender and organisation in relation to the NHS were carried out by Davies and Rosser (1986) and Harding (1989). These authors, like Hearn and Parkin, started from a position of asserting that women faced 'widespread latent discrimination' (Harding, 1989, p51) within the NHS, albeit that women comprised

three-quarters of the NHS workforce. Davies and Rosser assumed Kanter and Korda's perspective on power and gender in the workplace in asserting that the NHS had, in effect imposed a male career structure upon a female workforce, with expectations of full-time working, segregation of roles that were 'female' or 'male', and an absence of women from senior positions. These authors distinguished between 'administrative careers' and 'career administrators', arguing that the former were dominated by women in largely secretarial roles and the latter by men in senior management posts (albeit that the latter roles depended on the everyday administrative and management support of the women in the former category of roles).

Davies and Rosser described a 'hostile climate' (Davies and Rosser, p30) where policies and practices mitigated against women, pointing out that this was not a malign intent to channel women into a lower-status pathway, but more a function of underlying power structures (following Kanter's analysis, and prefiguring Acker's description of gendering processes). Harding concluded her analysis of the NHS in the late 1980s by calling for women themselves to make stronger claims for effective equal opportunities policies and capacity, combined with a change to the fundamental structuring of the organisation 'by and according to the wishes of the male worker.' (Harding, 1989, p62). It is striking that Harding, unlike many analysts of gender and organisation in the 1980s, did not stop at calling for more equality of opportunity, but moved to Myerson and Kolb's (2000) fourth frame in seeking a more fundamental challenge to the way in which careers and organisations were structured.

Alimo-Metcalfe (1991), in a paper that supported Davies and Rosser's assertion of the NHS being hostile to women, claimed that it was in fact a waste for such a large employer to systematically fail to make fuller use of women's talents throughout the many professions within it, thus calling on the 'organisational effectiveness' or 'business sense' argument in making her case. Alimo-Metcalfe noted in relation to general management: 'There have been no major research studies of women in management in the NHS, which in itself is interesting. However, there is substantial evidence that women are yet again conspicuous by their absence in senior management positions. Currently 17 per cent of unit general managers are female, and 4 per cent of district general managers' (Alimo-Metcalfe, 1991, p22).

Following the establishment of the NHS Women's Unit in 1992 (see chapter 2 policy context), research and policy analysis was commissioned by the NHS Management Executive as a basis for further action in respect of increasing women's representation in senior management and other roles in the NHS. In the report of this research, Goss and Brown (1991) pointed to factors impeding women's progression within the NHS such as: the long-hours culture in the NHS and the assumption this was critical to carrying out a managerial role; an unwritten rule that committed managers must change jobs on a regular basis; and a lack of family-friendly policies and flexible working arrangements. Interestingly, Goss and Brown also warned that the development of purchasing in the NHS following the market reforms of 1991 might lead to women becoming over-represented in purchasing authority management jobs, which they forecast risked being perceived as a 'soft area'. They proposed local targets for jobs where women were clearly under-represented and called for positive action to equip women with skills to enable them to move into top management posts.

In a paper in 1993, Alimo-Metcalfe noted: ‘The British National Health Service is the third largest employing organisation in the world. Seventy eight per cent of the total workforce are women, yet only four per cent are general managers’ (Alimo-Metcalfe, 1993, p70). She outlined the barriers faced by women in respect of career development in management, including a critique of selection processes, performance appraisal, and the attribution of success. In concluding the paper, Alimo-Metcalfe noted:

‘Chief executives need to be visionaries encouraging changes and challenge to the status quo, transforming cultures where past emphasis has been on ‘doing’ to ‘being’ values such as co-operation, belonging, caring and receptivity....It remains to be seen whether women will be enabled to offer such resources to the organizations that desperately need them’ (Alimo-Metcalfe, 1993, p80).

In 1998, the *Health Service Journal* examined the degree to which Opportunity 2000 goals for increasing the number women in the higher echelons of NHS management had been achieved (Snell, 1998). It pointed out that the Department of Health was the first government department to sign up to Opportunity 2000 in 1991, and that its goal had been to increase the number of women in general management posts from 18 per cent to 30 per cent (NHSME, 1992), via the setting up of the NHS Women’s Unit. The Unit was however disbanded in 1996 and in 1998, the number of women who were chief executives in NHS trusts was just 17% (Income Data Services, 1998). Snell suggested that women might have lost some of the ground gained in the early 1990s, and questioned whether the NHS Equal Opportunities Unit would be able to focus on the needs of senior women managers in the way that the Women’s Unit had been able to do.

Contemporary analysis of NHS management and gender has been led by Ford (2005) who carried out a detailed feminist critique of leadership research and applied this to the English NHS, thus drawing together the literature on leadership and gender within a critical management (as opposed to positivist) approach. She asserted that ‘the existing body of organisation and management theory assumes implicitly that managers and workers are male, with male stereotypic powers, attitudes and obligations’ (Ford, 2005, pp243-244). Ford drew on Gherardi’s (1995) work to assert that:

‘the cultural construction of femininity around bodies and emotions, and of masculinity around disembodiment and rationality, has made men ‘natural’ inhabitants of organisational life, whilst positioning women as out of place in organisations’ (op cit, p244).

In this way, Ford places herself in the feminist tradition of regarding women as ‘other’ or ‘object’ in relation to men as the ‘subject’, something that De Beauvoir outlined as a fundamental feature of women’s experience, as noted in chapter 1 (introduction). Ford makes a head-on criticism of NHS management in asserting that:

‘This favouring of masculinity and the pervasive associations between men, power and authority in organisations appears to have been taken for granted. Thus the literature and the practice of management have consistently failed to question its gendered nature’ (Ford, 2005 p245)

She goes on to cite the work of Fournier and Kelemen (2001) and Marshall (1995) that showed the effort that women have to make to present ‘viable public images’ that make them acceptable in the organisational world. This might entail seeking to be discreet and invisible, trying to display a lack of assertiveness, a downplaying of gender identity (trying to blend in as ‘one of the boys’), or as an honorary man

(Collinson and Hearn, 1996), or a female man (Marshall, 1995). There is however an element in Ford's work of assuming that the 'masculine' is associated with 'macho' behaviour, gender asymmetry, and notions of power and control, and that the 'feminine' is necessarily concerned with transformational or postheroic leadership (e.g. Ford, 2006), and likely to be less visible and favoured. This has echoes of Rosener's (1990) analysis of 'women leading differently' and Alimo-Metcalfe's (1998) drawing of a dichotomy between transactional and transformational leadership, analyses that were noted earlier in this chapter to run a risk of assigning women to certain roles, competences and styles of leadership in a way that belies the complexity of how leadership is performed by both men and women.

In a paper on public sector leadership in 2006, Ford asserted that discourses of leadership are understood typically to involve:

'core elements of masculinity that reinforce male identities and thereby sustain asymmetrical gender relations in organizational life' and that the masculine voice 'governs discourse and exchange'. (Ford, 2006, p81)

Although Ford drew on the work of Jeff Hearn in making the first part of this assertion, in a conference paper in 2008, Hearn made a challenge to Ford as to whether it was possible to regard masculinity in such a cut and dried manner, suggesting that there was a need for more subtle and nuanced exploration of what is meant by masculinity, albeit that leadership discourses do play a role in sustaining asymmetrical gender relations (Hearn, 2008). What is clear is that leadership discourse, like organisations, is inherently gendered. What is not so clear is how that gendering plays out in relation to understandings of what is masculine or feminine, particularly in view of emerging evidence of men assuming home-maker and

childcaring roles, women leaders as sole breadwinner, and complexity concerning the ways both men and women choose to enact their leadership.

The presentation of self by senior women in the NHS forms the third major theme of this study, as explored in the final thematic element of this literature review chapter. Ford highlights how senior managers in a local authority ‘story themselves’, make sense of how they lead, and choose to present themselves as ‘crafted selves’ (Kondo, 1990). In her paper in 2005 examining leadership in the NHS Ford explored the strength of NHS culture and its attempt to produce a leadership identity ‘that the individual can ‘manufacture’ or ‘adopt’ to fit the profile created by the dominant discourse of leadership in the NHS’ (Ford, 2005, pp246-247). Ford concluded her feminist critique of NHS leadership by calling for:

‘a research agenda that aims not only to adopt a culturally sensitive and locally-based approach, that takes account of individuals’ experiences, identities, power relations and intersubjectivities; but also one that allows for the presence of a range of masculine and feminine workplace behaviours’ (op cit, pp247-248).

This research is intended as a response to that challenge posed by Ford. Through a process of eliciting stories of career from senior women leaders in the NHS, the study seeks to explore how women ‘story self’, and within that ‘perform’ their gender, a topic that is explored in the next section below.

The performativity of gender

Judith Butler (1988) argued that gender is something that is ‘performed’ as a series of acts, and not a fixed or given identity. In other words, she chose to view gender as a construction and presentation of identities for ourselves and others, as opposed to sex

being something that is biologically defined. Butler drew on Beauvoir's claim that 'one is not born, but, rather, *becomes* a woman,' in making her assertion that gender is:

'the *appearance of substance*...a constructed identity, a performative accomplishment which the mundane social audience, including the actors themselves, come to believe and to perform in the mode of belief. If the ground of gender identity is the stylized repetition of acts through time, and not a seemingly seamless identity, then the possibilities of gender transformation are to be found in the arbitrary relation between such acts, in the possibility of a different sort of repeating, in the breaking or subversive repetition of that style' (Butler, 1988, p520).

Thus Butler argues that gender identity is created by means of a performance, a sequential acting out of behaviours that the audience perceives as gendered in some way. This interpretation of gender is within the social constructionist theoretical tradition, regarding the self as something that is constantly created and recreated (or performed and re-performed) and not an essential or core substance. This performing of gender and self, is not, according to Butler, a purely individual act – it takes place in a social context and according to rules, norms and scripts that were in existence prior to the individual's particular performance. The essential paradox of performing gender and self, yet of being located within a social context and discourse is explained by Butler:

'one is compelled to live in a world in which genders constitute universal signifiers, in which gender is stabilized, polarized, rendered discrete and intractable. In effect, gender is made to comply with a model of truth and falsity which not only contradicts its own performative fluidity, but serves a social policy of gender regulation and control' (Butler, 1988, p528).

Butler's work has been subject to significant challenge, including by authors such as Schwartzman (2002, p437) who argued that Butler's description of how social change

occurs (through restaging and resignifying language), fails to acknowledge the importance of social structures of power in making such acts of resistance possible, and hence potentially downplays the wider context of struggle for social liberation.

This view of Butler as ‘having an almost magical power to destroy progressive activism’ (Duggan, 1998) questions how far a view of gender as something that is ‘performed’ can contribute to reducing gender inequity, promoting equality of opportunity, challenging predominant leadership discourses, or whatever the overall aim of a gendered approach to organisational analysis might be. Disch (1999) draws together the value of regarding gender as something that is performed, with its inherent location within a socially constructed context that constrains the ultimate autonomy of the one doing the performance in asserting that Butler’s work represents:

‘resolute opposition to the construction of women as victims. This is not to say that she posits autonomy as the starting place (or even the goal) of feminism, however. To the contrary, Butler is a theorist of political subjectivity who insistently draws our attention to the fact that, as speaking beings, we are inescapably dependent “on a language we never made” in order to exist at all’. (Disch, 1999, p546)

Disch (op cit, p546) goes on to note that ‘there exists no standpoint of critique that is not sustained by and complicit with the forces it seeks to transform’, thereby underlining how performativity of gender is in itself embedded in the cultural, social, gendered and other contexts in which a particular individual is ‘doing gender’.

This is important context to the stories told by women chief executives in this research, who ‘perform gender’ as they relate their account of career, making that performance in a way that is, in Disch’s words, sustained by and complicit with the

culture and context of NHS management, and the UK public sector more generally.

The notion of performing gender enables a reading of the women's accounts as presentations of self and gender, yet we have to remain alert to the fact that each performance is in itself located in and shaped by other forces and influences.

Performativity enables a social constructionist approach to the gendered ways in which women tell their story of career and self. It throws light on the social context in which individuals 'do gender', and the fact that some choice is exercised in so doing, albeit that the choice is constrained by a range of social and cultural forces. However, Butler's work is not sufficient in itself as an analytical tool for use with stories of career, given that it stops short of exploring the complex power relationships that are critical to the gendered nature of organisations and the experience of the people who lead them.

Summary: gender in organisational life

This exploration of literature concerned with gender and organisational life reveals how a gendered approach to organisational analysis enables an exploration of the ways in which workplace practices can be part and parcel of 'gendering', and thus suggests ways in which steps towards greater gender equity might be taken. Feminist critique of organisational life focuses on the gendered and unequal power dynamics within organisations, and arguments of social justice, gender equity, economic rationale, and maximising women's distinctive leadership approaches are used as the basis for arguing that 'something must be done' to enable improved representation of women in senior management positions. Within the NHS, gender was regarded as a critical issue of equal (or rather unequal) opportunity in the 1980s and 1990s, with numerous attempts to explore how to 'fix the women' and enable greater opportunity.

That this was not sufficient appears to be confirmed by the persisting lack of representation of women in senior management positions. If change ‘from the fourth frame’ (Myerson and Kolb, 2000) is to be possible, a more sophisticated understanding of the gendering of organisations is needed, and Butler’s analysis of gender as something that is performed offers one such route to a different perspective on the nature and presentation of gender. To regard gender as something that individuals ‘perform’ offers the possibility of gender ‘coming in from the outside’ within organisations, as women and men narrate and create their workplace selves and thus reveal something of the power relations, culture and wider context within which organisational life takes place. This in turn might present a basis from which to challenge the organisation’s culture and mode of leadership, and perhaps to ‘change from the fourth frame’.

The storytelling of career and self

In this section, the nature of personal identity and self is examined, with a specific focus on the socially constructed self, and how such a self or selves are created and presented within narratives. Storytelling is also considered in relation to its capacity to enable the performance of self (and after Butler, gender). This is followed by an exploration of how the story of career can be told, with conclusions being drawn about the ways in which shifting, multiple (and gendered) selves may emerge from such stories when explored in a dialogical or poetic theoretical approach.

The nature of personal identity and the self

The idea of the self as ‘a valued social construction, reproduced time and again in everyday life’ (Holstein and Gubrium, 2000, p.ix) has its origins in the work of early

twentieth century intellectuals such as George Herbert Mead. In 1934, Mead noted that ‘The self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience’. The concept of the self was thus being asserted in a radically different way in comparison with the essential or transcendental self of Western social thought prior to the mid-twentieth century. No longer was the self ‘a single, simple, continuing, and unproblematically accessible mental substance’ (Gallagher and Shear, 1999, p ix), or, as described in Western Christian thought, something consisting of two distinct entities (the mind, or soul, and the body), where the mind/soul is what constitutes the self. It was now being considered as something constructed in the social context, and endlessly reconstructed in time and in place.

Holstein and Gubrium (2000) point to the continuing importance of a sense of self, despite the multiple social contexts which could be viewed as overwhelming to a sense of an individual self or selves:

‘It’s hard to deny that this allegedly embattled social entity remains something that we constantly act toward; we speak its interests as we design personal objectives, formulate actions, and achieve goals. It’s also an object we continue to act from; it provides motivation for what we say and do. Nearly everything we attempt or accomplish today is done in relation to what kind of selves we are...The self, in other words, is not only something we are, but an object we *actively* construct and live by’ (Holstein and Gubrium, p10).

Foucault (1977) pointed out that the concept of an individualised self (whether socially constructed or not) was a relatively recent phenomenon in Western history. He noted that ‘commoners’ had traditionally been regarded as extensions of ‘the crown’ and members of occupational or kinship groupings, and hence lacking what would now be regarded as individual personal identities. In Foucault’s terms, it was

the development of modern jurisdictions and the emergence of human sciences that enabled a sense of an individualised self (Holstein and Gubrium, 2000).

Garfinkel (1967) asserted that people engage in structuring their lives so as to appear meaningful, organised and coherent and Holstein and Gubrium built on this by asserting that:

‘in today’s world of proliferating sites and scenes of identity work, the self is increasingly an institutional project, something persons must continually manifest as a basis for making sense of their conduct and relationships....it is widely produced to account for who and what we are, eclipsing those subjectivities – the sovereign, the family, the tribe, the community – that in earlier times were our primary beacons and moral agents’ (Holstein and Gubrium, 2000, p12).

This reliance on the views of others in creating a sense of self draws on Foucault’s (1977) analysis of social control as being produced by exposure to ‘the gaze’, this being reminiscent of Beauvoir’s analysis of the self as object that exists in the eyes of others (*pour autrui*). This suggests that through assessment and measurement, individuals are ‘calculable’ and even ‘confessional’ as selves, colluding in their own subordination as workplace systems produce disciplined and even ‘conformist’ selves (Holstein and Gubrium, 2000). Contemporary organisational researchers such as Collinson (2003) suggest that modern employee monitoring and target-setting leads to ‘intensified visibility’ that requires individuals to develop survival strategies in order to resist, conform to, or act out the perceived desired self implied by the intense monitoring process (see below for more about this).

Sedikides and Brewer (2002) argued that there are three fundamental self-representations: the individual self; the relational self; and the collective self. They

suggested that people achieve self-definition and self-interpretation (identity) in three ways that relate to these representations of self: in terms of their own unique traits; in relation to dyadic relationships; and in terms of group membership. Sedikides and Brewer regarded these selves as co-existing within an individual, and as being social. This analysis clearly echoes elements of existentialist thought in relation to the creation of self in respect of oneself and others. However, Sedikides and Brewer point out that the relationship between the different representations of selves is the complex and problematic issue to consider:

‘There is considerably less agreement, however, about the nature of the interrelations among the three self-representations. Are the individual, the relational and the collective self close partners, bitter opponents, or indifferent acquaintances?’ (Sedikides and Brewer, 2002, p2)

This highlights the potential for both the crafting of selves (after Kondo) and also the co-existence of conflicting or contradictory representation of selves as illustrated in the work of Ford (2006).

Narrating the self

Foucault (1988) set out his interest in the ‘technology of self construction as follows:

‘I am interested in the way in which the subject constitutes himself in an active fashion, by the practices of self...[These practices] are patterns that he finds in his culture and which are proposed, suggested, and imposed upon him by his culture, his society and his social group.’ (Foucault 1988, quoted in Holstein and Gubrium 2000, p101)

In this way, Foucault, like Butler after him (and discussed in the previous section of this chapter), argued that individuals not only construct and present self (or selves), but these selves are necessarily a product of and constrained by the wider culture and

society within which the individual is doing their identity (and gender) work.

Holstein and Gubrium drew on this in their summary of the nature of narrative biography (the telling of stories of self):

‘Narrators artfully pick and choose from what is experientially available to articulate their lives and experiences. Yet, as they actively craft and inventively construct their narratives, they also draw from what is culturally available, storying their lives in recognisable ways. Narratives of the self don’t simply rest within us to motivate and guide our actions, nor do they lurk behind our backs as social templates to stamp us into selves according to the leading stories of the day. The narrative landscape of self construction is clearly also a busy one’. (Holstein and Gubrium, 2000, p103)

The importance of regarding the self as multiply constructed, and constantly unfolding within narrative and discourse was underlined by Hall (1996) in a paper reflecting on the nature of identity:

‘...identities are never unified and, in late modern times, increasingly fragmented and fractured; never singular but multiply constructed across different, often intersecting and antagonistic, discourses, practices and positions... Precisely because they are constructed within, not outside, discourse, we need to understand them as produced in specific historical and institutional sites within specific discursive formations and practices, by specific enunciative strategies’ (Hall, 1996, p17).

Dorinne Kondo’s (1990) work concerning ‘crafted selves’ as revealed within women’s stories of their lives offers an insight into how different selves can be thus woven into a ‘crafted whole’. Kondo’s work was based on an ethnographic study of the lives of working class women in a Japanese factory, during which time Kondo worked alongside the women in the factory (and being herself half Japanese). Hence, there was a significant reflexive element to Kondo’s approach. To some extent Kondo’s approach had resonances for the author of this study as being a former NHS manager and management trainee who was researching ‘what she might have

become'. This reflexivity is explored in more depth in chapters 1 (introduction) and 4 (methodology). Kondo explains her approach to accounts of 'the problematic of self-hood' as follows:

'...the product of a complex negotiation, taking place within specific, but shifting, contexts, where power and meaning, "personal" and "political", are inseparable. Identity is not a fixed "thing", it is negotiated, open, shifting, ambiguous, the result of culturally available meanings and the open-ended, power-laden enactments of those meanings in everyday situations. [...] Writing freezes the complex dance of domination and counter-domination, of approaching and drawing back.'" (Kondo, 1990, pp24-25).

In the chapter exploring her theoretical and methodological approach which has a strong existentialist feel to it being concerned with subjects conferring meaning upon objects (entitled *The Eye/I*), Kondo explains her approach to her account of the women she encountered thus:

'I attempt to avoid positing in advance the unproblematic existence of a unified, rational, coherent, bounded subject, looking instead to see "selves" as potential sites for the play of multiple discourses and shifting, multiple subject-positions' (Kondo, 1990, p44).

It is this multiple nature of the self asserted by Hall, Holstein and Gubrium, Kondo and others that underpins analysis of the stories of career told by women chief executives in the research reported in this thesis. Kondo's assertion of a 'multiply crafted selves' appears to offer some form of 'solution' to the inherent messiness and complexity of social constructionist views of self and identity. However, this does raise a question as to whether the crafting of multiple selves is not in fact a move towards an implied unified or more single self.

Whilst the idea of ‘crafting’ of selves into a narrative account makes sense as part of the conceptual framework for analysing the stories told by women in this research, it is open to question as to how far such accounts could be a crafting of something that is implicitly whole or persisting. Instead, it is important to retain Kondo’s sense of multiple and shifting selves revealed within language (and located in the dialogic interpretation of social constructionism – see chapter 4 for more on this) , recognising that although writing (or capturing a narrative on tape) ‘freezes the complex dance’, it does not of itself assure a multiply crafted self, rather a snapshot of a complicated and fluid process of the presentation and narration of self. Foley (2002) summed up the approach of autoethnographers such as Kondo as follows:

‘They seek to undermine grandiose authorial claims of speaking in a rational, value-free, objective, universalizing voice. From this perspective the author is a living, contradictory, vulnerable, evolving multiple self, who speaks in a partial, subjective, culture-bound voice’. (Foley, 2002 p474)

That Kondo’s work is hard to classify, and at times frustratingly might appear to be located between a performative and essentialist view of self, is explained by Martin and Collinson (2002) in a paper reviewing the academic field of ‘gendered organisations’. They describe the work of Kondo (and others such as Bruni and Gherardi, 2002 – see chapter 7) as:

‘freed from mainstream constraints, they can work inductively, creating new concepts and methods that can explore and examine the multiple conditions, meanings and consequences of ‘gendered’ work’ (Martin and Collinson, 2002 p257).

Before examining literature concerning the ‘storying of career’, the nature of storytelling itself is considered.

Storytelling and performance

Stories are recognised as being a powerful way of communicating feelings and experience. Winstanley (2001), made the following observation:

‘Stories have their own power which is different to that of myths. There is a power of healing that can come from being witnessed, being believed, being heard. This is the power which the audience gives the story-teller[....] ...there is also a role for reinterpretation. The capacity to work with the past, present and future in a more iterative way opens up the possibility of choice and freedom’ (Winstanley, 2001, p17).

The importance of stories as a vehicle for individuals to give coherence to their lives has been asserted by Denzin (1989) and Hyvarinen (1996). Denzin pointed out:

‘what must be established is how individuals give coherence to their lives when they write or talk self-autobiographies. The sources of this coherence, the narratives that lie behind them, and the larger ideologies that structure them must be uncovered’ (Denzin, 1989, p62).

Sveningson and Alvesson (2003) called this form of storytelling ‘identity work’, whereby people form, maintain and revise their personal narratives as they attempt to achieve ‘a sense of coherence and distinctiveness’ (p1165). This resonates with Butler’s work on the performativity of gender, Ford’s work exploring the contradictory discourses used by managers (see below) and with Grey’s assertion of the importance of the career story as a project of ‘self-management’ (see also below).

Boudens (2005) highlighted the importance of regarding ‘stories of work’ as ‘stories of workplace emotion’, and points out that people rarely talk about just the mechanical aspects of their jobs, they draw in material that reflects what they feel as

they interact and transact with others. She also made the crucial observation about analysing narratives that:

‘Stories are, of course, attempts to persuade...there is not objective recounting of the facts against which to evaluate how and how much the narratives are embellished’ (Boudens, 2005, p1303).

Despite this caveat, Boudens advocated for the use of narratives as a rich source of organisational research material, given that they are grounded in the individual and his or her emotions and experience, and hence revelatory of the wider collective experience of the workplace and working life.

In a similar vein, Grint (2000) takes the concept of the leader as a person with potentially multiple selves within different contexts, and argues that a successful leader is one who can construct, and continue to reconstruct, versions of their own and their followers’ identities in a way that engages and motivates those followers towards the leader’s cause.

In the research reported here, individual narratives of senior women managers are used as the basis for analysis of the role and experience of such senior leaders, both in relation to how they use language in order to tell a story of career, but also how, in so doing, they co-construct and present different selves with the listener, reveal varying and at times contradictory discourses, and shed light onto some of the ‘identity work’ and ‘workplace emotion’ that is part and parcel of being a senior executive. In the next section, the use of a career as a central project for a story is examined.

The methodological approach used within this research seeks to chart a course between those theories concerned with the performance of selves within specific institutional settings (that is, a dialogical approach), whilst retaining the insights of the more critical literature as explored in the ‘gender and organisation’ section of this chapter. The way in which this methodological dilemma was managed during the research is explained in chapter 4 (methodology).

The story of career

Grey (1994) used a large case study research project within a major accountancy firm, together with a review of literature, as the basis for developing the concept of a career as a personal project, ‘a relatively well-defined scenario within which individuals may develop, express, and create themselves’ (p481). He asserted that the project of self-management linked home and work, leisure, dreams and daydreams – and also that it linked past, present and future ‘through the vector of the self’ (op cit, p481). Drawing on existentialist thought that regards a human being as the sum of the projects they have undertaken, as expressed by the self in relation to others (a further link to the work of De Beauvoir and Sartre), Grey asserted that:

‘Career links present, past and future through a series of stages, steps or progressions. Career offers a vehicle for the self to ‘become’ (op cit, p481).

Grey explained that the pursuit of career was a self-discipline that could only be operationalised within the workplace, but was not produced within nor confined to the workplace. This is an important point in relation to the experience of the NHS chief executives in this study whose careers were being operationalised within PCTs and

NHS trusts, but, as is seen in chapter six, were clearly a product of different sets of family, educational, political, religious and other experiences.

In examining Grey's work on career as a project of self-management, there is a need to be mindful of the fact that the study on which the analysis was based took place in an organisation that, being a large accountancy firm, might be regarded as the epitome of white, male and Western workplace culture (and Grey acknowledges in the paper that the subjects of the research were overwhelmingly white and male). As such, it represents a particular form of masculinised work environment (and one that was studied over fifteen years ago) where the drawing together of work and home networks into the overall 'career project' might be regarded as a form of corporate culture not necessarily typical of the wider and more current working world. Indeed, references to the importance of a 'well-packaged wife' (p493) and the role of golf club, Round Table and dinner parties in seeking to 'go to the top' could likewise be regarded as anachronistic.

However, it is of note that on reading this paper for the first time, I was struck by the similarity between some of what was described and what emerges in this PhD research about NHS management culture. The notions of 'enthusiastic trainees', a focus on 'getting to the top', the importance of conformism to the prevailing leadership culture, a strong culture of surveillance and performance measurement from the top, the resulting insecurity for senior managers, and hence the telling of the story of career as a project of one's self – these resonated as accurate depictions of the culture and expectations apparently experienced by NHS senior managers in the early 21st century. In recent research within large law firms in Australia (Cornejo et al,

2008), the continuing importance for career progression of male networks (social/professional) and of the ideal worker as ‘essentially male and care-less’ has been underlined, suggesting that the corporate culture portrayed by Grey is far from dead within at least some organisational contexts.

For some researchers, this masculinised cultural construct of ‘care-less’ workers for whom the career is the project of self will only be able to be challenged and changed where a ‘tipping point’ is past and the ratio of women to men moves over 30% (e.g. Chesterman et al, 2005) and a ‘critical mass’ of women assume senior management roles. Indeed, these researchers, having studied over 250 senior executives from different sectors across Australia found that both men and women agreed that the presence of women in senior roles had changed management cultures and influenced methods of decision-making. Chesterman et al concluded: ‘in line with Billing and Alvesson (2000, p146) our research reveals that “management and leadership are decreasingly constructed in strongly masculine ways”’. However, there was caution exercised about how far such change was yet embedded in organisations, for Chesterman et al emphasised that

‘the corporate environment where power and business overlap is the natural environment for white men and it is this naturalness that enables them to preserve the status quo [...] What we would argue is that while male participants revealed widespread acceptance and even pleasure in the different norms and ways of working arising from the presence of women, it was the women who drove the change [...] it was very easy for these changes to be reversed when women moved out of senior positions and the gender balance at this level tilted back towards male dominance.’ (Chesterman et al, 2005, p13)

Interestingly, despite the optimistic assertions about women forming a ‘critical mass’ within organisational leadership, Chesterman et al concluded that the failure within

organisational culture to address deep-seated concerns about ‘work-life balance’ (for both men and women) and to fundamentally question the ways in which working lives are constructed represented the maintenance of a core barrier to the ‘feminisation’ of management. In a comment that will be reflected on in respect of the NHS in chapter 7 (discussion), these authors concluded:

‘The intensification of work demands, the difficulties of managing a work/life balance and the investment in workplace visibility and access suggest a trend towards “re-masculinising” management rather than rupturing masculine norms of managing.’ (Chesterman et al, 2005, p19)

Grey, echoing Foucault’s (1977) work on ‘the gaze’ and associated discipline and conformism, concluded that career was a powerful force in relation to control of people, particularly in respect of the ways in which people’s performance is measured and managed – the sense of career management exerting social, economic and personal control for individuals and organisations. Thus:

‘In the new subjectivity of the managed self, career is of prime importance. In contrast to the unintelligibility, chaos and paradoxical nature of social relations in general, career offers at least the potential for the management of the self through ‘steps on the ladder’ or ‘moves in the game’....this self-disciplined project of self-management through career is a more productive and economical form of management control than disciplinary power, with its costs and unintended consequences, could ever be’ (op cit, 495).

Thus for Grey, the act of making a career a ‘project of self-management’, or a ‘story of self’ was not only high-risk, but could be associated with a significant degree of insecurity. Indeed, Grey’s work takes a critical management approach in regarding the concept of career as an instrument of control or discipline within the workplace (and is part of what Mabey and Finch-Lees [2008] coin a ‘critical Discourse’) – a

point that is returned to in chapter 4 when examining how the theoretical approach to this research influenced the selection of research methodologies.

That the power of organisational culture is sufficient to create insecurity and demand conformism, making any challenge to that culture intensely difficult, echoes Chesterman et al's rueful conclusions about 'the gendered impact of a critical mass of women'.

Collinson (2003) explored the analytical importance of such insecurity for understanding the survival strategies senior managers might adopt within an organisation. Like Grey (and De Beauvoir and Ford), he adopted what can be described as an existentialist standpoint of regarding the individual as a self in opposition to others, and considered the inherent separateness of this as being the initial source of insecurity that people feel within social situations, including at work. Collinson went as far as to suggest that the pursuit of career success can assume religious proportions, noting:

'the validation of self through career success, material accumulation and the confirmation of 'significant others' can become a new and highly influential religion (Walter, 1979)' (op cit, p530).

For Collinson, the very importance of the project of career is, combined with increasing material wealth in society, the source of insecurity that is experienced by people engaged on such a pursuit of career. Like Grey, he points to the role of workplace monitoring and motivation systems in intensifying people's insecurity at

work, and takes the analysis forward by setting out how people seek to survive ‘the gaze’ of surveillance through a range of survival strategies.

Collinson (2003) identified three survival strategies, the first of which was conformism, including: ‘careerism’; working long hours; competing to be successful and ‘splitting self’, that is dividing identity between work and the ‘real me’. Secondly he pointed to dramaturgy: the manipulating of self, reputation and image in the eyes of ‘significant others’; the manipulation of information and performance data; choreography of individual practice; and management of reactions to situations. Finally, Collinson noted the role of resistance as a strategy for survival, suggesting that this included: the construction of an alternative and more positive sense of self beyond that provided by the organisation; whistle-blowing; foot-dragging; subversive behaviour; cynicism; humour; and an adherence to avowedly different values, in opposition to the prevailing organisational culture.

Both Grey and Collinson pointed to the complex nature of how leaders ‘story the self’, and the importance that is attached to a career project intended to portray the individual as a coherent weaving together of different experiences and perspectives into a story presented to a gazing world. Chesterman et al (2005) throw light on the masculinised nature of the workplace environments in which research by Grey, Collinson and others took place, and offer insights into the potential of a ‘critical mass’ of women at senior levels of management to start to challenge and change such prevailing culture, and in particular the notion that work should be ‘care-less’ and divorced from home and family life.

In the final section of this review, the notion of ‘crafting multiple selves’ (Kondo, 1990) is used as the basis for setting out how, in this research, stories of career told by senior women leaders in an organisation approaching the ‘tipping point’ of a third of women leaders, have been analysed as representations of multiple and gendered selves.

Crafting multiple selves

Research into leadership within local government in the UK undertaken by Jackie Ford (2006) concluded that leaders tell their story of career in a way that reveals not only multiple, but also contradictory, discourses of self. Ford drew on Grey’s concept of the career project and Collinson’s sense of its inherent insecurities, using analysis of discourse to expose the fluid and competing nature of selves that feature as ‘projects of the self’. In her study of 25 senior managers in a local authority, Ford identified the ‘complex, fragmented and contradictory interplay of the four dominant discourses’, these being:

- professional career;
- social and family;
- macho-management; and
- postheroic leadership.

Ford analysed the different discourses used by managers when talking about their careers and workplace experiences as the basis for a deeper exploration of the way she believed that they constructed and portrayed their multiple selves:

‘These managers forge their lives and identities within the tumultuous environment of change and uncertainty in the UK public sector. Their identities revealed both simultaneous and different selves, bursting with complexities and deeply felt, nuanced and often contradictory elements’ (Ford, 2006, p96).

As explored earlier in this chapter, Ford’s approach to the gendered nature of organisational discourse can be critiqued in respect of an apparently clear distinction between ‘masculine’ (e.g. macho-management) and ‘feminine’ (e.g. social and family) discourses within leadership. Nevertheless, the identification of a range of contradictory discourses within narratives of career, based on critical feminist analysis offers an important insight into how gender can intersect with and inform managerial and leadership behaviour in relation to career aspirations and expectations placed on women and men within managerial roles. In this way, Ford builds on and extends Kondo’s work, both in highlighting the multiple discourses present in stories of career as project, and in addressing the issue of gender within the portrayal of selves in workplace narratives. She explains the value of her approach by making a call for more such critical research into the issues of gender and leadership (as she did in her 2005 paper on a critical feminist approach to leadership):

‘The complex inter-relations between discourse, gender and identity dynamics are not only hidden but also considerably under-explored in organisational life and are worthy of further research investigation’ (op cit, p97).

As a response to this challenge from Ford, the analytical framework used for this research into the stories of career told by women chief executives in the NHS is one that considers the interview data as an exploration, in the dialogical tradition of social constructionism (see chapter 4 for more detail about this), of the multiple selves co-constructed by the women and the researcher as they recounted gendered stories of

leadership in health services in difficult times. Kondo's concept of shifting and 'multiply crafted selves' forms the primary strand of analysis, the stories being examined through a dialogical theoretical lens as revealing multiple selves created through the use of language within a narrative encounter, these selves including leader, mother, partner, employee, daughter, sister, and friend. Grey's work (in the critical discourse) on the career as a project of self-management represents the secondary dimension of the analysis, with the stories of multiple selves being also considered as 'stories of career' and hence of an attempt to manage a self when subject to the discipline or control of a career. When examining the ways in which the women chief executives sought to overcome the insecurity associated with making the career a project of self-management, Collinson's strategies of conformism, dramaturgy and resistance are applied, these again reflecting a critical discourse standpoint whereby the control of career or workplace requires a response that seeks to resist or otherwise deal with that control. In exploring the fluid (or at times anxious) selves within the stories, Ford's work on gendered and contradictory discourses of leadership is used as the means by which discourses are identified and then compared within and across stories.

Summary: the storytelling of career and self

Taking a view of the self as social, dialogical, and endlessly reconstructed through the use of language in human interactions, the telling of a story becomes an important means through which individuals will seek to make sense of themselves and try to perform this to the watching (or rather listening) audience. Although multiple and shifting, the different selves will be crafted into something more 'whole' by the

narrator (albeit transitory as captured by the text), for as humans we seek to create a sense of continuity and cohesion through this process of storytelling.

The career can become a core project within storytelling, especially for those who rise up through masculinised corporate-type organisational hierarchies where career is regarded as a form of discipline that lends order to the workplace. Senior roles are however inherently insecure, subjected as they are to the gaze of many observers, and strategies will need to be adopted in order to mitigate this insecurity. To seek to understand the nature and experience of leadership when in senior roles, the eliciting of stories of career and self offers an opportunity to try and unravel and examine shifting, and multiply crafted selves. Furthermore, a critical lens of gender can be applied to the analysis, seeking to understand stories of leadership told by women chief executives who work as part of a minority population within gendered and arguably powerful organisations.

Chapter summary

This review of the literature of the demography of health services management, gender in organisational life, and the storytelling of career and self points to some key questions about the nature and experience of being a senior manager in the NHS in the UK. The position of women as a minority community is revealed, and in particular for those women working as chief executives in acute hospitals. The relative lack of progress in increasing the proportion of women chief executives is also striking, along with a sense that much effort was expended on this issue in the 1990s, but somehow gender may now have been ‘done’ (or in Fletcher’s terms, have disappeared) with less policy attention now being paid to gender. However, if a social

justice, gender equity, or indeed a business management, argument is applied to the issue of gender representation in senior management, the NHS continues to face a challenge as to how it can develop a 'critical mass' of women leaders, and find ways of changing its leadership culture 'from the fourth frame' in Myerson and Kolb's (2000) terms.

Literature from the wider sphere of gender, work and organisation suggests that the challenge for the NHS is one of reflecting on and addressing issues of power, culture, and the prevailing requirements of 'what a senior manager should be'. Whilst much attention in the past has been placed on addressing issues of flexible working and other human resource management issues, the literature points to something more profound in respect of the conception of what a leader should be, how their working life should be constructed, and what the organisational culture expects. This raises questions about how far women are comfortable with and able to work within such roles and expectations, and of how they therefore need to construct themselves as leaders, partners, mothers, colleagues and so on. More importantly, a fundamental challenge is posed to the NHS about the model of culture and leadership that it seeks to espouse, and how far that model will address the known factors that sustain numerous 'gendering processes' that reinforce barriers to progress for women and other minority groups.

Career can become a 'project of the self' and a way of making sense of one's life as a sequential whole. Eliciting stories of the career project within a dialogical theoretical framework has been shown to be a way of divining something of the way in which people craft their sense of self (or selves) through the lens of career. For leaders who

are very much in the 'gaze' of others, these stories represent their attempts to construct and perform certain selves, to address the insecurity and anxiety of their role, and to try and assert or craft some cohesion even when it may feel anything but that.

The main area of interest for the second phase of this doctoral research was that in telling their 'story of career', women chief executives who form part of a minority population in the NHS would, individually and collectively tell a 'community of stories' that would shed light on what it is to be a woman leader in the NHS. The literature points towards a need to analyse those stories as a set of narratives that reveal shifting and multiply crafted selves, and to explore the contradictory nature of the discourses within the narratives. In the next chapter, an account is given of the theoretical and methodological journey travelled as the research was carried out, including how the challenge of charting a course between dialogical and critical theorists was managed, as a preamble to examining the demographics of the NHS chief executive population and then hearing and analysing the stories of career of ten women chief executives.

CHAPTER 4

METHODOLOGY

Introduction

This chapter describes, explains and reflects on the methodological approach used for this study. Firstly, the research questions are set out, along with an explanation of how analysis of data collected for the first stage of the study informed the development of questions for the second stage. Secondly, an explanation is given of the methods of data collection and analysis used to address the research questions. In the third section, the overall theoretical approach to the research is set out, with a particular focus on how this related to the methodologies selected, and the ways in which research data were analysed. The fourth section then sets out the methods used in analysing data, with a particular focus on the narrative analysis of the ten chief executives' accounts, and including a reflection on the nature of my own reflexivity within the research. The fifth and final section of the chapter reflects on the methods used in the study, and considers how far the methods enabled the drawing of conclusions that are at once relevant the project's aims and also enable a distinctive contribution to be made to the literature on health care management and leadership.

The research questions

The original principal research question for this study was:

Who are the chief executives of primary care trusts in England, and in what ways, if any, do they differ from the population of chief executives of NHS trusts?

The research question concerned finding out how far the population of PCT chief executives differed from the population of NHS chief executives in NHS trusts.

Possible areas of difference were deemed to be:

- gender – an assumption that a greater percentage of PCT chief executives were women, in comparison with NHS trust chief executives;
- age – an assumption that a greater percentage of PCT chief executives were younger, compared with their NHS trust counterparts; and
- chief executive experience – an assumption that a greater percentage of PCT chief executives were in their substantive first chief executive post.

In order to establish whether or not PCT chief executives as a group did differ from the wider population of NHS chief executives, and to ascertain whether there was any basis to the above assumptions, it was necessary to establish the profile of the population of the PCT chief executives. There was also a need to determine the population profile of comparator NHS trust chief executives, and thus paint a complete picture of the NHS chief executive community in England. To achieve these objectives, a national postal questionnaire survey of NHS chief executives was carried out in England in 2003 and then repeated for follow-up purposes in 2006.

The first stage of the research (2003 survey questionnaire – see chapter 5) revealed that the population of chief executives of primary care trusts differed significantly from that of NHS trusts. These differences included: gender; age; salary; and career

history. This led to a decision to use the second stage of the research to explore the aspirations, role and experience of women chief executives. The rationale for this decision was that there were proportionately more women than men in chief executive roles in primary care trusts, whilst the percentage of women in acute trust roles had hardly changed over the previous decade. This led to curiosity on the part of the researcher in relation to the experience of women chief executives, in both primary care trust and acute trust settings. The main research question for the second stage of the study was therefore:

What is revealed about the role and experience of women chief executives in primary care trusts and NHS trusts, when women are asked to tell their story of career?

Possible areas of significance in relation to the role and experience of women chief executives were considered to include:

- the way in which they chose to tell their story of career;
- the selves that the women chose to present when telling their story of career;
- the influence of family life on their work experience;
- the business and organisational priorities that women set for their role as chief executive;
- the way in which women conceptualised the role of chief executive;
- the factors that they considered to have been a particular influence on their career story;
- the factors that motivated them in their role as a chief executive;
- the factors that frustrated them in their role as a chief executive; and
- their aspirations in relation to their future career beyond the current post.

In the next section, a description is given of the data collection and analysis methods selected for use in order to answer the research questions set out above.

Methods of data collection and analysis used to address the research questions

The research for this study took place in two main phases, reflecting the two overall research questions identified above. The first phase comprised a postal questionnaire survey being sent to all chief executives of NHS trusts and PCTs in England in 2003, along with analysis of data to distil key themes and questions for examination in the second phase. The second phase took the form of a follow-up postal survey questionnaire of NHS chief executives in England, and a set of in-depth interviews with women chief executives in NHS trusts and PCTs in England.

Ethical approval

This study was carried out within the NHS Research Governance Framework (Department of Health, 2001b), given that it entailed empirical research using NHS staff as research subjects. An application for research ethics approval of the 2003 survey questionnaire of all NHS chief executives in England was made in March 2003 to the Trent Multi-Centre Research Ethics Committee. A copy of the letter of approval for this ethical application is attached at appendix 1.

In July 2006, a further application for ethical approval of the follow-up survey questionnaire, and also the in-depth chief executive interviews, was made to the West Midlands Multi-Centre Research Ethics Committee. A copy of the letter of approval for this ethical application is also attached at appendix 2.

In both cases, applications required that all research tools, consent forms, and participant information sheets be scrutinised and approved by the research ethics committees. Both in 2003 and in 2006, minor changes were asked for by the research ethics committees, and approval was granted following the initial consideration of the application, and then chair's action in respect of completing the minor amendments.

Programme of research

In table 4.1 overleaf, the programme of research for this study is set out in detail, illustrating how the different data collection and analysis methods related to the research questions that underpinned the project.

Table 4.1: Programme of research, related to research questions

Phase one research	Data collection method used	Data analysis method used
<p>Who are the chief executives of primary care trusts in England and in what ways, if any, do they differ from the population of chief executives of NHS trusts?</p>	<p>Review of literature on the mapping of the chief executive population of the NHS (see chapter 3).</p> <p>Literature review findings used to shape a postal survey questionnaire intended to update and extend earlier studies of NHS chief executives.</p> <p>Pilot postal survey questionnaire of all NHS chief executives of trusts and primary care trusts in Scotland (n=28) in July 2002.</p> <p>Chaser letter sent to non-respondents (n=8) in August 2002.</p> <p>Total response (n=24) representing a response rate of 85.7%.</p> <p>A question was included about the questionnaire itself, with respondents invited to comment on the questionnaire and their experience of completing it.</p>	<p>Data inputted into a database and descriptive statistical analyses carried out using cross-tabulations, pivot tables, and simple counts. Statistical testing performed in order to test significance of conclusions.</p> <p>Results of analysis used to write a report that summarised key findings and set out a picture of the population of NHS chief executives in Scotland.</p> <p>Experience of undertaking and analysing the survey used as the basis for scoping the main postal survey questionnaire.</p>

	<p>Successful application for ethical approval of the main postal survey questionnaire research made to the Trent Multi-Centre Research Ethics Committee (March 2003).</p>	<p>Feedback from ethics committee used to inform final version of postal survey questionnaire.</p>
	<p>Main postal survey questionnaire of all NHS chief executives of trusts and primary care trusts in England (n=578) in April 2003.</p> <p>Chaser letter sent to non-respondents (n=230) in May 2003.</p> <p>Total response (n=451) representing a response rate of 78%</p> <p>Analysis of postal survey questionnaire used to frame a review of the literature concerning gender and health services management (see chapter 3).</p> <p>Literature review findings used to scope stage two research on the role and experience of women chief executives in NHS trusts and primary care trusts.</p>	<p>Data inputted into a database and descriptive statistical analyses carried out using cross-tabulations, pivot tables, and simple counts. Statistical testing performed in order to test significance of conclusions.</p> <p>Results of analysis used to write a report that summarised key findings in relation to each question, and set out a picture of the population of NHS chief executives in England.</p>

Phase two research		
What is revealed about the role and experience of women chief executives in primary care trusts and NHS trusts, when women are asked to tell their story of career?	Successful application for ethical approval of a follow-up postal survey questionnaire, plus a set of in-depth interviews, made to the West Midlands Multi-Centre Research Ethics Committee (July 2006).	Feedback from ethics committee used to inform final drafting of interviewee consent and briefing materials.
	<p>Postal survey questionnaire of all NHS chief executives of trusts and primary care trusts in England (n=403) in November 2006.</p> <p>Chaser letter sent to non-respondents (n=185) in December 2006.</p> <p>Total response (n=250) representing a response rate of 62%</p>	<p>Data inputted into a database and descriptive statistical analyses carried out using cross-tabulations, pivot tables, and simple counts. Statistical testing performed in order to test significance of conclusions.</p> <p>Results of analysis used to write a report that summarised key findings in relation to each question, and set out a picture of the population of NHS chief executives in England.</p>
	In-depth semi-structured interviews (of between one and two hours) carried out by the principal investigator with ten women chief executives, five from NHS or foundation trusts and five from primary care trusts (November 2006-January 2007).	<p>Interviews were recorded (with one exception where consent was refused) and contemporaneous notes taken. On the same day as the interview, the researcher made notes reflecting on the experience of the interview.</p> <p>Recordings were listened to and transcribed by the researcher.</p>

	<p>Literature review carried out focusing on the storytelling of career and self.</p> <p>Selected papers were read in order to shape a framework for further analysis of the women's accounts.</p>	<p>Transcripts were read and re-read by the researcher. Following a review of literature on the storying of career and self, a decision was made to use narrative analytical techniques.</p> <p>For each interviewee, a document was prepared that set out the main themes and discourses.</p> <p>These ten summary documents were then used as the starting point for analysis of the ten accounts as a 'community of stories' (Chase, 1995).</p> <p>Based on this thematic and discourse analysis, a literature search of papers related to the core themes was carried out.</p> <p>A pluralistic conceptual framework (drawn primarily from within the dialogic tradition of social constructionism, supplemented by elements of critical and constructivist Discourses [Mabey and Finch-Lees, 2008]) was developed by the researcher, this being concerned with viewing the women's accounts as stories of career and self, and examining how the women used the opportunity to tell their story as a forum for developing 'multiply crafted selves' (Kondo, 1990).</p>
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		<p>A technique of 'core story creation' (Emden, 1998) was used in order to develop a focused version of each woman's story of career and self.</p> <p>The core stories were then analysed using the pluralistic conceptual framework of career and the crafted self referred to above, resulting in the development of a set of six dilemmas. These were distilled within a process of exploring 'the narration of the self' (Holstein and Gubrium, 2000).</p>
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As can be seen from table 4.1, the quantitative study (postal survey questionnaire in 2003 and 2006) was used in order to develop a descriptive overview of the population of NHS chief executives in England. The development of this survey was based on a review of literature concerning the mapping of the chief executive population in the NHS (see chapter 3). Analysis of the descriptive overview from the 2003 survey questionnaire enabled the core focus of stage two of the research (the role and experience of women chief executives in primary care trusts and NHS trusts) to be developed, based on a review of literature about gender and health services management as set out in chapter 3.

The qualitative research in stage 2 (in-depth semi-structured interviews) enabled an exploration of the narratives (presentation and crafting of selves) of women chief executives in primary care trusts and NHS trusts, this taking place within a pluralistic conceptual framework that was devised from a review of literature concerning the storytelling of self (see chapter 3, and the next section of this chapter below). A second phase of quantitative study in 2006 (repeat of postal survey questionnaire) enabled updating of the 2003 survey, and analysis of changes to the descriptive overview of the chief executive population, as context for analysis of the chief executives' narratives. This narrative analysis revealed a set of six dilemmas within the 'community of stories' told by the women chief executives, and the dilemmas were used to frame the writing up of findings from the qualitative research, and to shape discussion about overall conclusions from this study.

The postal survey questionnaire

As described earlier in this chapter and summarised in table 4.1, it was considered important to map the population of NHS chief executives, from both PCTs and NHS trusts, in order to be able to explore the characteristics of the two groups and to hence explore areas of similarity and difference. In order to gather demographic information from chief executives, a postal survey questionnaire was selected as the most appropriate method. This was on account of the lack of availability of information about NHS chief executives in the public domain, apart from their name and organisation (these being available on NHS websites). The postal survey questionnaire was designed in order to answer the following research questions:

- who are the chief executives of PCTs in England?

- in what ways, if any, do they differ from the wider population of chief executives, i.e. chief executives of NHS trusts?

Ferlie (2001) noted that the questionnaire may be the most popular research method used within organisational studies in health care, especially when ‘countable’ data are to be collected. He also pointed out that a mailed survey is typically used to collect basic descriptive information about populations of health care organisations, this representing a useful technique for capturing structural data, but poorly adapted to handle ‘more nuanced data’ such as ‘where does the power really lie?’ (Ferlie, 2001,p30). It is for this reason that the postal questionnaire of chief executives was used as the means to compile demographic information about the overall (and differentiated PCT and NHS trust) population, whereas in-depth semi-structured

interviews were undertaken in order to access more nuanced, personal and detailed data about women's experiences of being a chief executive.

Details of the survey questionnaire, how it was designed, piloted and administered in 2003, and again as a follow-up in 2006, are set out in chapter 5 of this thesis.

Analysis of data from the 2003 postal survey revealed that there were significant differences in the two populations of chief executives (PCT and NHS trust) as follows:

- PCTs had a significantly higher percentage of women chief executives than NHS trusts;
- PCT chief executives had a younger age profile than their NHS trust counterparts;
- PCT chief executives were more likely to have worked in primary care or in a health authority before coming to their current post; and
- more PCT chief executives were in their first substantive chief executive post of an NHS statutory body.

This analysis led to the development of two areas of focus for the second phase of this research study: the difference between PCT chief executive roles and the chief executive role in NHS trusts; and the experience of women chief executives, in both PCTs and NHS trusts. This analysis informed the design of the second phase of

research, namely a more extensive exploration of the experience of women chief executives in PCTs and NHS trusts by means of in-depth semi-structured interviews, and a further postal questionnaire survey of NHS chief executives of PCTs and NHS trusts in late 2006 as a means of tracking the demography of the chief executive population.

Reviewing the literature

The literature review element of this research took place in three main phases.

The initial review was focused on studies examining the population of chief executives in the NHS, and was intended as background to the mapping survey first carried out in 2003. This review took the form of an electronic literature search using HMIC, HELMIS, Medline, CINAHL, Health Business Elite and Embase databases, and used the keywords: chief executive; chief officer; general manager; and top manager. These keywords were linked with descriptors: health care organisations; NHS; hospitals; primary care organisations; primary care groups; primary care trusts; multifunds; total purchasing projects; independent practitioner associations; physician groups; commissioning; and purchasing. This review resulted in 164 papers being identified, of which 40 related to hospital managers, and 25 focused on primary care management, were selected for in-depth review and inclusion in this part of the literature review.

The second review carried out in 2005 following analysis of data from the initial mapping survey was focused on gender in health services management. This review was again carried out electronically and used the keywords: gender; organisation;

women; men; health management; female; male; NHS; and equal opportunity. These were linked with the descriptors: chief executive; top manager; chief officer; and general manager. The same databases were searched as in 2003, and resulted in 86 papers being identified, of which 32 were identified for in-depth review. This literature review was repeated and extended in 2007 when writing up the PhD thesis, and this time took a wider focus beyond health management, using snowballing techniques (manual/electronic journal searches and internet Google Scholar searches) to examine key papers and sources related to gender and management.

The third review was carried out in 2007 when analysing interview data and was focused on the storytelling of career and self. The review was carried out electronically, and supplemented by manual searches as advised by PhD supervisors who are expert in this area of literature. Keywords for this review were: self; identity; storytelling; narration; career; social constructionism; and leader. These were linked with descriptors: gender; manager; organisation; work; chief executive; and top manager. Databases used were: ASSIA, HMIC, ISI Social Science Citation Index and EBSCO. Results from this review were supplemented by snowball searching of electronic journals to follow up on specific citations. 23 papers were reviewed in-depth for this stage of the review, and six methodological books were read or consulted.

Interviews with ten women chief executives

As noted in the opening section of this chapter when examining the research questions that guided this study, the overall aim of the second phase of the research was to undertake detailed analysis of the experience of women chief executives in NHS

trusts and primary care trusts, and, as a result of deciding to undertake narrative analysis of accounts given by the women, to examine how they presented and crafted different selves. Since the work on gender in health care management during the 1980s and 1990s that is explored in chapter 3 (literature review), there appeared to have been relatively little empirical research carried out in this area in the UK, and in particular no work was found that had been informed by the significant emerging theoretical material on storytelling, self and career. Hence this exploration of the stories of a sample of senior women leaders in the NHS was intended to represent an important update to the analysis and discussion of senior women's experiences in the NHS in the 1990s (e.g. Goss and Brown, 1991; Alimo-Metcalf, 1991; IHSM Consultants, 1994), carried out within the emerging theoretical work concerned with self and storytelling..

The primary research question for the second stage of the research was to explore how far gender was a significant factor in the 'difference' of PCT chief executives from their NHS counterparts. Possible areas of significance in relation to the role and experience of women chief executives were considered to include the issues set out on pages 108-109 in the opening section of this chapter, e.g. how women choose to tell their story of career, the selves they choose to present when telling their story, and the influence of family life on career.

In order to explore these potential areas of significance in relation to women's experience, it was decided that an in-depth qualitative study focusing on the issue of gender and senior health services management, and in particular the narratives of women chief executives in relation to their career and family life, would be carried

out. In parallel, it was decided that a repeat of the 2003 postal questionnaire survey should be undertaken, as explained above. An explicit decision was taken not to interview male chief executives. This was on the basis that women continued to form a minority group within the chief executive population, and the eliciting and analysis of their stories was deemed to be a topic deserving specific attention, as the focus of the research was shifting to the role and experience of women chief executives.

Methods for the study of the role and experience of women chief executives

In order to access the narratives of women chief executives about their individual experience and situation in the NHS, an in-depth semi-structured interview was carried out by the principal investigator with five female PCT chief executives and five female NHS trust chief executives between November 2006 and January 2007. This method was chosen on account of its ability to enable focused exploration of an individual's experiences within an interview that is guided by a thematic schedule (Britten, 1995).

Given that this study had already collected demographic data in 2003 that enabled a description of the chief executive population, and was repeating this demographic survey in November-December 2006 in order to update the national chief executive profile, semi-structured interviews were deemed to enable a more in-depth and qualitative assessment of chief executives' experiences at an individual, as opposed to whole population, level. In addition, given the emerging interest of the researcher during the study in collecting and analysing narratives of career, the semi-structured interview setting was considered appropriate for eliciting such narratives or stories.

The timing of the interviews (November 2006-January 2007) was chosen in order to enable new PCT organisational arrangements to have been put in place following the changes pursuant on the policy of Commissioning a Patient-Led NHS (Department of Health, 2005) – see chapter 2 (policy context) for more background to this. One hundred and fifty newly reconfigured PCTs came into being on 1 October 2006, and it was this new cohort of PCTs that was used as the population for sampling to select PCT chief executives for interview.

Chief executives were selected for interview using a two-stage process. A database of all women chief executives in the NHS in England was created using a commercial database of NHS chief executives (Binleys On-Line), with chief executives being flagged as either working in a PCT or in an NHS trust/foundation trust. The database was cross-checked against the website www.nhs.uk where all NHS organisations and chief executives were listed, this being considered important as a checking mechanism at a time of reorganisation of NHS bodies and their boards. On 4 November 2006, the database contained names and contact details of 58 PCT women chief executives and 79 NHS trust/foundation trust chief executives. It should be noted that for PCTs, some organisations still had no chief executive in post, or acting arrangements in place. Organisations that were apparently without a substantive chief executive were excluded from the sampling for this study.

Mays and Pope (1995) drew attention to the importance of qualitative research employing sampling approaches that were systematic and non-probabilistic, aiming not for a random or representative sample, but to identify specific groups of people who possess characteristics relevant to the social phenomenon being studied. They

justify this ‘purposive sampling’ approach as enabling exploration of a particular aspect of behaviour relevant to the research, and hence suggest the explicit selection of participants with access to important sources of knowledge. Purposive sampling of the database of women chief executives was thus carried out in this study as a way of ensuring access to the experiences of women in senior management positions within both PCTs and NHS trusts. The sampling used the following dimensions:

- equal numbers (ten of each category to allow for non-response or refusal) of NHS trust/foundation trust and PCT chief executives, given the study’s interest in the potential differences between these two population ‘types’; and
- geographical spread of respondents across England (no more than two in any strategic health authority area), given an interest in ensuring that respondents were drawn from different strategic health authority areas in the NHS which themselves have different bosses (chief executives) and potentially distinctive management cultures.

The sampling resulted in twenty women chief executives being written to by the researcher in early November 2006, with an invitation to take part in this second stage of the research (a copy of the letter is attached at appendix 3). The letter included information about the overall aims of the study and the role of these semi-structured interviews in the research project. It also gave an indication of the time the interview would take, the topics to be covered, who would carry out the interview, in what location, and how data would be recorded and confidentiality assured. The letter also explained that appropriate ethical committee approval had been secured for the study

(from the West Midlands NHS Multi-Centre Research Ethics Committee), and assured the recipients that they would receive a copy of the report of this stage of the research, and a copy of any papers that are published using the findings of the study. A participant information sheet and consent form were also enclosed (copies attached at appendices 4 and 5). Recipients of the letter were asked to complete the consent form and return it to the principal investigator, indicating whether or not they were willing to take part in the interviews.

This resulted in ten chief executives being selected for interview from across six regions of the NHS in England. Details of the specific regions are not included here, in order to help preserve the anonymity of the women interviewed. Details of the chief executives' identities are known only to the researcher and her PhD supervisors. Tapes and notes were coded and stored in a locked cabinet at the University of Birmingham and at the Victoria University of Wellington (the researcher's employing university and the university where she was based during analysis and writing up of research data), these data being kept separate from the coding schedule. In analysis and reporting of interview data, labels of 'chief executive A, B etc' were allocated to all ten women, and these have been retained in the presentation of findings in this thesis. Furthermore, where chief executives referred to colleagues by name in their interview, pseudonyms have been used in order to protect the confidentiality of those colleagues referred to by respondents.

It was decided that interviews should take place in the chief executive's office at their PCT or NHS trust/foundation trust, given that it was not felt to be realistic to expect senior managers to travel from their place of work to another location for a research

interview. They were however all offered the possibility of a different, neutral, location being booked by the researcher if they preferred. Nine of the interviews took place in the chief executive's office. One interview was carried out at the local strategic health authority headquarters, at the request of the interviewee, who was at that building for other meetings on the day of the interview.

The interviews lasted between one hour and two hours, with 90 minutes being the average length. Nine of the interviews were recorded and subsequently transcribed by the researcher. In all ten interviews the principal investigator took contemporaneous notes. One chief executive refused consent to taping and her interview was therefore written up on the basis of the contemporaneous notes. Immediately after each interview, the researcher made notes about her reflections on the interview process, including:

- information about the office in which the interview took place, including any personal photos and information that were evident;
- thoughts about the building and site where the interview took place;
- reflections on the demeanour and mood of the chief executive;
- notes about the interview process, including if the researcher was kept waiting or not, and how she was received;

- reflections on discussion that took place after the tape was turned off, which in some cases lasted for upwards of 30 minutes; and
- overall sense of how the interview had gone, how it made the researcher feel, and how the process concluded.

These notes were returned to by the researcher when carrying out analysis of the ten narratives as ‘stories of career and self’ and, where appropriate, are referred to in chapter 6 where the key dilemmas within the narratives are revealed. The notes were considered to be important contextual material that helped to answer questions about the ‘how’ as well as the ‘what’ contained within the stories of career and self (Holstein and Gubrium, 2000).

The interviews were based on a semi-structured interview topic guide that is attached at appendix 6. Within the interviews, areas explored included the following:

- the chief executive’s story of her career;
- the intersection of home and family life with this story of career;
- factors that she felt had been influential within this story of career;
- what motivated the chief executive in her role;
- what frustrated the chief executive in her role;

- how she conceptualised the role of chief executive;
- what business and organisational priorities she has set for her role;
- what, when she looked back, she considered to have been the main influences on her as a woman chief executive;
- her career plans and intentions for the future; and
- an invitation to talk about any other issues she felt to be relevant.

Following completion of the interviews, a letter of thanks was sent to each chief executive, reiterating how they could gain further information about the study, the fact that their data would be analysed, stored and written up in a confidential manner, and explaining how they would receive feedback on research findings.

Theoretical perspectives underpinning the research

A pluralistic approach

The ways in which research is analysed and reported are inevitably the result of choices made by the researcher, and are reflective of what the literature refers to as different paradigms (Kuhn, 1970) or world views (Feyerabend, 2000). The Kuhn view of scientific paradigms asserts that these are incommensurable and not open to constructive dialogue (Peck and 6, 2006), a view similar to that of Burrell and Morgan

(1979) who likewise contest that paradigms within social theory and organisational analysis are mutually exclusive, and by accepting one set of assumptions, the researcher denies the others (Mabey and Finch-Lees, 2008). Feyerabend (2000) argues however that pragmatic processes of negotiation, dialogue and mutual understanding between world views are possible, apparently building on Gioia and Pitre's (1990) proposition of the value of 'constructing bridges' between the concepts in different theoretical paradigms. In the research reported here, Feyerabend's assertion of the value of negotiating and drawing upon multiple world views is assumed as the basis for adopting a pluralistic approach to the analysis of data collected in this study. This thus enables what Mabey and Finch-Lees (2008, p15) refer to as 'the possibility of "rising above" commitment to any single ontological stance in order to assess the comparative contribution of the conflicting theories in any given research domain'. As is explored below, this research assumes a pluralistic approach, primarily drawing on a dialogical theoretical perspective, yet also making use of critical, constructivist and functionalist lenses.

As a way of mapping the theoretical perspectives underpinning this research, Mabey and Finch-Lees' (2008) framework of four Discourses of management development is used, this framework having been adapted from one developed by Schultze and Stabell (2004). This framework has been selected due to its ability to encompass combinations of theoretical perspectives, blends that enable a nuanced insight into research data, and which support and explain a pluralist research approach.

The four discourses identified in Schultze and Stabell's work and adapted for the Mabey and Finch-Lees framework are: the functionalist; the constructivist; the

critical; and the dialogic (see figure 4.1 overleaf). Mabey and Finch-Lees assert the value of using this framework as follows:

‘Schultze and Stabell trace more carefully than most the theoretical assumptions underlying extant research. . This helps to cue us in to contrasting, and on occasions conflicting, literatures [...]Furthermore, as has become clear, the advantage of Discourses over paradigms, is that they are not intended to be theoretically watertight boxes and their permeability allows us to be more imaginative about the way they might flow into each other’.

(Mabey and Finch-Lees, 2008, p22)

The relevance of this framework to the research reported in this thesis is the possibility of exploring theoretical approaches to leadership and management research in a pluralistic manner, in combinations, or in a way that Mabey and Finch-Lees describe as ‘flowing into each other’.

A pluralistic theoretical approach enabled different research methods to be used in order to extend and enrich insights from data gathered. For example, a functionalist perspective as applied within the survey questionnaire (a quantitative method in the positivist tradition) had the benefit of providing background information about the demography of the chief executive population in England. The pluralistic approach supported the use of a dialogic lens through which to view the stories of the women chief executives gathered during in-depth interviews (exploring the presentation and construction of multiple selves within narratives), supplemented by insights from others of Mabey and Finch-Lees’ quadrants (see table 4.2), namely the critical

(examining the powerful and predominant gendered model of NHS management) and
constructivist (performing gender and resisting the predominant management culture)
discourses.

Table 4.2 Four discourses of management development (MD) research

<p>Dialogic Discourse</p> <p>Metaphors of MD: discipline, carnival, reproduction, dressage</p> <p>Role of MD in organisation: a vehicle for the active construction of identities which are themselves inherently multiple, shifting and negotiated</p> <p>Theories: post-structuralism, feminist post-structuralism, postmodernism, deconstruction, Foucauldian social theory</p> <p>Research domains: MD as discourse, identity construction within MD, deconstructing the language of MD</p>	<p>Critical Discourse</p> <p><i>Metaphors of MD:</i> political struggle, religious conversion, cultural doping</p> <p><i>Role of MD in organisation:</i> to produce and resist order, predictability, control, domination, subordination</p> <p><i>Theories:</i> critical theory, labour process theory, some forms of feminism</p> <p><i>Research domains:</i> MD as a means to either change or preserve the balance of power within organisations. MD's role in perpetuating capitalist ideology.</p>
<p>Constructivist Discourse</p> <p>Metaphor of MD: drama</p> <p>Role of MD in organisation: enabling collective learning and self-development, conferring meaning/status</p> <p>Theories: agency, role behaviour, learning, resource-based, theories of practice, sense-making</p> <p>Research domains: modes of MD and their outcomes, cultural significance of MD</p>	<p>Functionalist Discourse</p> <p><i>Metaphor of MD:</i> a tool-kit</p> <p><i>Role of MD in organisation:</i> building skills and knowledge to address performance gaps and optimise resources</p> <p><i>Theories:</i> intellectual capital, open systems, RM, institutional, contingency, resource-based</p> <p><i>Research domains:</i> performance impact of formal MD activities, evaluation studies</p>

Source: Mabey and Finch-Lees (2008), p23

In relation to the 'journey of the research' a functionalist starting point (the survey of the chief executive population) led to a concern to make an analysis of the chief executive population within a critical and feminist discourse. Following interviews

with women chief executives, their accounts were explored using narrative analytical techniques that assumed a dialogical perspective, whereby multiple selves were presented, negotiated and co-created with the researcher, and language was the means through which this exploration was made. As noted above, critical and constructivist discourses were also drawn upon in order to offer further insights, as reflected in the selection of literature to underpin the analysis of research data.

Two types of social constructionism

The theoretical approach adopted in this research was broadly aligned with social constructionism. It is however hard to identify *one* social constructionism. Ford et al (2008) suggest that there are at least two approaches to social constructionism: a cognitive or sense-making approach (as typified by writers such as Gergen [1994]) who asserted that narratives are the ways we make sense of our selves and our lives and that we become agglomerations of many different selves as we shift rapidly from one site of interaction to another (Gergen, 1991, Gubrium and Holstein, 2001); and a poetic approach (as typified by writers such as Shotter [2008]) who writes of a more sensuous approach to social constructionism, where ‘language and the world are intertwined in a dialogical or chiasmic relation with each other, in which we are shaped just as much, if not more, by the world, as the world by us’ (Shotter, 2008, p501).

Shotter’s (2008) approach echoes the existentialism of Beauvoir referred to in chapters 1 and 3 when he emphasises a poetic approach to social constructionism as being concerned with the ‘becoming’ of selves through language and interactions with others:

‘to switch to this very different view of language is also to switch to a very different view of the world in which we live: it is to see it as a living dynamic, indivisible world of events that is still coming into being’ (p501).

This poetic approach described by Shotter echoes Mabey and Finch-Lees’ dialogic discourse that underlines the role of language in presenting and shaping multiple selves, whereas the sense-making approach of Gergen appears more allied to Mabey and Finch-Lees’ constructivist discourse that focuses on the conferring of meaning and status through narrated experiences.

The dialogic discourse

For the analysis of interview material within this research, the dialogic discourse is the primary theoretical standpoint assumed, albeit supplemented by insights from other quadrants within Mabey and Finch-Lees matrix. Mabey and Finch-Lees (p102) echo the work of Shotter when describing the dialogic discourse as where ‘persons and their worlds are continuously in process’, and an ontological approach of *becoming* is assumed. Thus in the context of this research, the dialogic approach was concerned with how the women chief executives, in the telling of their story, were creating selves (or co-creating selves with the researcher), shifting back and forth as indicated in the work of Kondo (1990) and Holstein and Gubrium (2000) referred to in chapter 3 and used as the basis for analysis of the women’s narratives.

A dialogic discourse, as the name implies, gives prominence to language, the means by which reality is constructed. Ford et al (2008) assert the value of a dialogic

approach to leadership development and research on the basis of its ability to be more reflexive, critical, situated (within context) and enabling exploration of how individuals relate to others at work. Ford et al (p178) explain their application of the dialogic approach as follows:

‘By “dialogical” is meant, literally, dialogue, but the subject who is engaging in dialogue with others will also have numerous discourses at work constructing their own subjectivities (how we speak to ourselves), and it is necessary to “tune into” these discourses through which we speak to ourselves so as to understand how the self is constructed.’

In the conclusions to their book exploring leadership as identity, Ford et al reiterate the need for a dialogic approach to be ‘critical, reflexive and intersubjective’ (p181) and go on to assert that ‘Dialogic exchanges present the opportunity of moving away from universal understandings to examine the unique elements which unfold in personal exchanges’ (op cit, p181). In the research reported in this thesis an explicitly reflexive approach has been adopted, and as is noted later in this chapter, that reflexivity is approached as ‘intersubjective reflection’ (Finlay, 2002) which in Finlay’s words entails an exploration of the co-constituted nature of the research, looking at both inward meanings and outward into the realm of shared meanings, interaction and discourse.

Foucault’s technologies of the self

Thus this research is located within Foucauldian social theory that regards knowledge as socially constructed, and discourse (and within the dialogical approach, discourse

as reproduced in language) as being the means by which social practices produce knowledge. The women's narratives are explored as knowledge produced within a specific social interaction between researcher and chief executive, this knowledge both being reproduced by the women and also reproducing the women and in a reflexive sense, this takes places as a co-constituted and intersubjective enterprise between each woman and the researcher (Finlay, 2002).

Foucault used the term 'technologies of the self' to describe the ways in which an individual 'constitutes himself in an active fashion, by the practices of self...[these practices] are patterns that he finds in his culture and which are proposed, suggested, and imposed upon him by his culture, his society and his social group' (Foucault, 1988, quoted in Holstein and Gubrium 2000, p101). Gubrium and Holstein (2001) described Foucault's technologies as 'knowledge systems' or 'truth games' associated with the techniques that people use to make sense of life experiences, and to construct themselves as certain kinds of people. Foucault asserted that the self is constituted through the power of discourse – in other words, identity is a product of discourse, for words come to create the identity they intend to describe (for example, descriptions of gender create a 'norm' relating to gender, by which men and women come to measure the extent to which they meet such 'norms' (Ford et al, 2008, p132). It is this connection of discourse with the power to create identity and self (or selves) that underpins the dialogic approach. In the analysis of narratives carried out within this research, the primary standpoint assumed was that through dialogue, multiple selves were being presented and created (and co-created with the researcher in an intersubjective manner) by the women, and that this discourse was a product of the cultural context within which the women work, live and told their story.

Explaining the choice of methodologies

The adoption of a particular overall theoretical standpoint for the analysis of interview data in this research (namely a dialogic approach) necessarily impacted on the method of analysis of the women's narratives, and drew me towards narrative analysis that sought to identify and explore the multiple selves presented by the women as they sought to construct and perform (after Butler, 1988) certain kinds of person or self through the medium of their discourse. In this way, I approached the narratives as accounts of 'identity under construction' within the Foucauldian tradition. Likewise, the inclusion of elements of the critical discourse (approaching the narratives from a feminist standpoint that assumed that organisations are gendered) and of the constructivist discourse (regarding the narratives as co-created by researcher and respondent), influenced the process of data analysis and the drawing of conclusions from the research.

The methodological journey could however have been very different. As it was, the use of Kondo's work on the crafting of multiple selves within discourse' along with Ford's contradictory and gendered discourses, led the analysis of the women's narratives into a dialogic domain, where the presence of multiple, and shifting, selves was assumed, and an exploration of their stories as dialogic discourses was undertaken. In regarding the women's stories as 'projects of career and self-management' (Grey, 1994) the analysis also drew upon elements of a critical discourse that regards the 'career' and other facets of the workplace as instruments of discipline and control that in turn shape the individual's sense of their self or selves. Similarly, Collinson's (2003) work on the insecurities associated with making the

career a project of self-management, and the inherent need to find survival strategies in the face of such insecurity (dramaturgy, resistance and conformism – see chapter 3), draws on a critical discourse wherein power relations in the workplace evoke certain responses which in turn are expressed in the narratives told by the women and the selves revealed therein.

If however a different theoretical standpoint had been assumed as the primary approach to this research, say within a functionalist discourse, the methodological journey might have been as follows. Having carried out the national mapping survey questionnaire and determined that women chief executives were a minority population within the NHS, a second and more in-depth postal survey could have been administered to all women chief executives, or indeed to a sample of men and women chief executives, asking them questions about their role, what they do within their job, what satisfies them about their job, what frustrates them, and so forth. This would have been likely to enable a more detailed description of the chief executive population and what individuals do within their roles. Furthermore, comparisons between men and women in relation to interpretation of role could have been made. Within such an approach, a positivist lens would have been used whereby an attempt was made to gain ‘objective’ data about the chief executive role, and its interpretation by men and women. This sort of approach would have been likely to lead to discussion about the chief executive task, role and activities, the extent to which men and women approach their role in different ways, and the drawing of comparisons with research literature about the ‘work that managers do’ in health and other sectors.

Alternatively, the adoption of an overtly critical theoretical standpoint might have taken the research in a markedly different direction. For example, the research could have assumed a more explicitly feminist or Marxist approach whereby NHS organisations were regarded as situations where women are necessarily oppressed and marginalised, with their interests being ever subservient to those of men as the persisting majority and powerful population of managers. Within such an approach, women might have been interviewed in-depth about their experience of being a ‘woman in a man’s world’, asked specifically to talk about any examples of discrimination they had faced, and to talk about how they thought their experience of being a chief executive differed from that of men. Furthermore, an explicitly critical approach might have focused on analysis of the discourse used within NHS policy on senior management recruitment, development and expectations, including an examination of recruitment materials, national leadership frameworks and competences, and policy guidance about the chief executive role. Taken together with interview material, and survey data about the position of women within the NHS (and in this frame, a further survey gathering more data about women’s pay, promotion, training etc. might have been undertaken), an overall feminist analysis could have been made about the arguably marginal position of women within senior NHS management.

Whilst an element of this critical approach is present in the analysis presented in this thesis (for example in the assertion that the women share a dilemma as to whether to try and resist or challenge the prevailing masculinised model of NHS leadership), the focus on exploring dilemmas within the narratives echoes much more strongly what

Ford et al (2008) call the ‘anxieties’ revealed within dialogic studies of self and leadership.

The implications of choice of theory

That I made certain choices in relation to both theoretical approach and hence to selection of methodologies, reflects the inherently pluralist, reflexive and emergent nature of this research. What is important however is to be clear that the very making of choices meant that certain constructions of the women chief executive were created and presented, ones that would have been otherwise, had different theoretical lenses been applied. The potential for different theoretical approaches (and different individual researchers) to approach and interpret data in contrasting ways is explored in a paper by Honan et al (2000) where three researchers each carry out their own analysis of data drawn from an ethnographic study of a child within her class room at school. The three readings of the data (via discourse theory, feminist poststructuralist framing, and ethno-methodology and conversation analysis) produce different and distinct ‘Hannahs’ (Hannah is the child’s pseudonym), one as a practitioner and negotiator of discourses, one as a subject of power who is able to position herself to surpass the limits she faces, and one as a participant in interactive research who engages in the production of who she could be taken to be (Honan et al, p30). Honan et al make a telling and important challenge to researchers in relation to the theoretical standpoint they might assume:

‘It seems a useful question to ask of any qualitative or quantitative work: what type of subject is being produced through theory and/or analysis? The descriptive and analytic texts that we produce are themselves documents

revealing the constitutive effects of discourse [...] A corresponding question that arises as well is whether any reading is as much about Hannah as it is about the reader/analyst herself.' (Honan et al, p30-31)

This underlines the necessarily reflexive, intersubjective and co-constituted nature of the research reported in this thesis, and the vital importance of the choice of theoretical lens through which the study was designed, carried out and analysed. In table 4.2 below, some of the potential alternative constructions and presentations of the selves of the women chief executives are mapped onto Mabey and Finch-Lees matrix of discourses of leadership and management research.

Table 4.3: potential alternative presentations of the women chief executives within differing theoretical discourse positions, as applied to Mabey and Finch-Lees' matrix of discourses of management and leadership research and development

Dialogic Discourse

Women chief executives as facing dilemmas in relation to motherhood, the role of partners, the ascription of success, and their response the prevailing model of NHS leadership. Discourse as constitutive and co-created.

Critical Discourse

Women chief executives as an oppressed and marginal minority, still after decades struggling to 'break through', meaning young women managers face insurmountable barriers of discrimination. Women as fundamentally 'different' in how they manage and hence experience their roles.

Constructivist discourse

Women as making sense of their role through their stories, using symbols, myths, rituals, etc to explain what it is like to be a chief executive as well as a mother, partner, friend, employee and so on. A sense of ongoing construction of identities within different settings and for different audiences. The use of a psychodynamic lens is another possible constructivist approach, using psychoanalytical theory to examine dynamics between leaders, followers, the organisation and individuals.

Functionalist Discourse

Women as an objective group within the NHS management population, distinct in how they describe and interpret their role and shown to be 'different' from men in certain ways that they choose to work and manage. The group portrayed as 'a typical sort or sorts' of manager, from certain backgrounds, experience, etc.

Enacting the theoretical approach within data analysis

In this section, an account is given of how the theoretical approach described in the previous section was applied within analysis of the ten narratives collected in the interviews with women chief executives. Through narrative analysis of the stories told by the women of career and self, an attempt was made to explore how they ‘crafted the multiple selves’ they chose to present within their account (Kondo, 1990), assuming a primarily dialogical approach.

Storytelling

In gathering the accounts analysed in this research, the women were explicitly asked to adopt a story-telling approach, for each interview was opened up with the question: ‘tell me your story, about how you got to where you are today. It is up to you where you start and what you cover – personal issues, work, education and so on’. In this way, the stories are located firmly within the narrative tradition, and the researcher was evidently conducting the interviews with a specific focus on narrative (as discussed by Hansen, 2006; Rosenthal, 2003).

The women’s narratives were thus regarded as a set of stories gathered within in-depth interviews. Storytelling is acknowledged to be an important method of capturing the experiences of individuals within organisations, both as individuals and as a collective of stories. The value of storytelling is considered to lie in its offering of an entry point into understanding organisational culture (Boyce, 1996) and also as a means of performing (Butler, 1988) or narrating the self or selves that a person chooses to present within their account (Kondo, 1990).

Narrating the self

Holstein and Gubrium (2000) asserted in relation to ‘narrating the self’ that: ‘One source of convergence would surely be the recognition of the artful yet locally constructed stories that comprise the contemporary self in practice’ (Holstein and Gubrium, p103). As noted in chapter 3 (literature review) these authors went on to explore how ‘the storying of the self is actively rendered and locally conditioned’ (p103). This reflects what, in this research, was elicited from the interviews with the ten women chief executives, when, as Holstein and Gubrium asserted (p103), ‘Over and over, we are relearning that selves are constructed through storytelling’.

Narrative practice is, according to Holstein and Gubrium, a form of interpretive practice. They assert that considering the self in terms of narrative practice:

‘allows us to analyze the relation between the *hows* and *whats* of storytelling; analysis centres on storytellers engaged in the work of constructing identities and on the circumstances of narration, respectively’. (Holstein and Gubrium, 2000, p104)

Thus the storytelling process is:

‘both actively constructed and locally constrained. Put differently, our approach is concerned with the activeness and spontaneity of performativity...and attending to the narrative resources and auspices implicated in storytelling, on the other’ (op cit, p104).

As explored in chapter 3 (literature review), performativity within the women chief executives’ accounts was explored in relation to how they chose to perform their gender (Butler, 1988), in other words, the stories told by the women were approached as performances of gendered selves. The intention within the narrative analysis of the ten accounts was therefore to concentrate on exploring the ‘hows and the whats’

of the stories that were told, examining not only what was said and the themes or plots that revealed, but also *how* the stories were crafted, what was included or excluded, consistencies and inconsistencies in the accounts, the metaphors used, and so on. The results of this analysis are set out in chapter 6 (hearing the stories told by the women chief executives) of this thesis.

Narrative analysis of the women's stories

Narrative analysis was selected as the primary method of analysis for the ten stories recounted by the chief executives in the semi-structured interviews. This decision was based on a belief in the potential of detailed examination of narrative texts as a means of revealing something of the standpoints, preoccupations and concerns of the women, both as individuals and, when taken as a 'community', of a 'class' of chief executives. Emily Hansen (2006) draws on Grbich (1999) to assert the value of narrative analysis and of stories:

'Narrative analysis is an exciting way to take advantage of the richness of qualitative data and it allows the researcher to gain (and to convey to readers of their write-up) insight into the beliefs, actions and values of participants, from within their own frame of reference....Understanding our data in terms of stories is a recognition that the issues/instances that emerge in our research are not isolated but in fact are embedded in people's lives, and that their understandings of their lives are constructed through language and interaction' (Hansen, 2006, p 153).

Gareth Williams' paper (1984) about people's personal stories of living with rheumatoid arthritis is considered to be a landmark within the use of narrative analysis (and particularly within healthcare settings), based on what his analysis of patients' stories revealed about their experience of illness within a broader personal and social context. Williams' particular contribution to this methodological literature was

concerned with the value of capturing the story as told, and then exploring the text of that story as the basis for seeking to understand the teller's standpoints, sense of self, and discourses. Williams explored how different patients made sense of their illness and situation, and what the text of their story had to say about what it was to be chronically ill, what was important to them, and how this went way beyond a traditional biomedical understanding of living with chronic disease. The chief executives' stories, when listened to over and over again and analysed within the narrative psychological tradition described by Holstein and Gubrium (in relation to both how things were said and what was said), and in an overall theoretical framework that took a primarily dialogical approach to the exploration of the intersubjectivity of respondent and researcher as expressed within language, likewise revealed much that was beyond what might typically be expected in an account of being a senior woman leader.

It should be noted here that the lack of a tape recording for one interview did impede the process of narrative analysis of that interview to some extent, for the contemporaneous notes were the sole record of the story. The written record was inevitably limited by the filter that the investigator had applied when taking the notes, and also in being shorter and 'edited' in comparison with the full record of the other nine interviews.

The analysis set out in chapter 6 (hearing the stories told by the women chief executives) reveals dilemmas concerned with motherhood, partners, organisational values and model of leadership, as well as what might be expected in terms of a story of career path, success, aspiration and so forth. It is these dilemmas (or in Ford et al's

[2008] terms, anxieties) that seemed to define the overall set of stories, for it is within these that the process of analysis seems to start to extend and perhaps explain the more 'formal' discourse of career. It was as chief executives that these women were selected for interview, however the narrative analysis opened up a wider story of guilty and regretful mothers, spirited organisational fighters, victims of discrimination, and individual battling with dissonant personal and organisational values.

An earlier study that explored narratives told by women chief executives was that of Susan Chase (1995) concerning superintendents of school systems. She analysed in-depth interviews with women in these roles, setting out the:

'diverse ways in which a professional career can be narratively assembled by those located in what for them amounts to an occupational borderland [being female and of different racial backgrounds in a white and male-dominated profession]' (Holstein and Gubrium, 2000, p 108).

Chase set out four case studies as a way of trying to answer her question as to why the stories end up being so different, despite them all being about professional power and success, and also about discrimination. Her conclusion was that although stories were sought and told in relation to success and discrimination, they invoked different discourses, devices for categorisation, and narrative linkages. These differences were speculated to be the result of the women drawing on different cultural experiences and world views associated with their context, as explained by Holstein and Gubrium (2000, p110) when reflecting on Chase's work: 'Regardless of the outcomes, the narratives would still have to be assembled with an eye toward the context in play. A

comparison of contexts would shed light on the sorts of options context makes available for storying the self.’

Narrative analysis of the women’s stories demonstrated how the women both consciously set out, and more sub-consciously revealed, multiple discourses and subject-positions, as can be seen in table 4.4 below that sets out an example of the themes and discourses identified when analysing the one of the ten narrative accounts (chief executive G).

Within the narrative analytical approach used in this research, ‘discourse’ was defined as existing at the intersection of social activity and the use of grammar (Martin and Rose, 2003). Thus an examination was made of the way in which grammar was used to represent, enact and organise the women’s presentation of self. ‘Theme’ was defined by DeSantis and Urgarriza (2000, p362) as: ‘an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature of basis of the experience into a meaningful whole.’ In the narrative analysis applied to the ten accounts given by the women chief executives, this sense of a theme as capturing and unifying expressed experience into some form of meaningful whole was what the researcher was seeking to create as the narratives were read, and presentations of experience were drawn into themes that were intended to convey meaning about the women’s self or selves.

Table 4.4: summary of themes and discourses in one of the chief executive interviews

CEO	Themes	Discourses	Summary
Chief executive G	Granting and refusal of opportunities	Of gender as a key and defining issue	Energetic, driven actor
	Men who helped or hindered	Of effort and achievement	
	Stay at home husband	Of activity, movement and challenge	
	Trying to be transformational in face of transactional culture	Of transformational leadership, culture change and service improvement	
	Need to be like a man to succeed	Of family and husband as anchors	
	Commitment to the service, patients and deprived areas	Of regret at friendships lost or neglected Of acting a role	

Thus the ten chief executives set out personal stories within the ‘full round of everyday concerns’ (Holstein and Gubrium, 2000, p105), as crafted on a single occasion, linked to the circumstances of the telling. As a set of narratives, analysed individually and then as an overall collective, they reveal dilemmas that characterise how these women apparently experience, conceptualise and create their ‘crafted selves’.

Core stories

As a precursor to analysis of the set of narratives, the stories told by the women chief executives were developed into ‘core stories’ (Emden, 1998) that seek to capture the importance and heart of each account. An example of one of these core stories is set out in appendix 7 of this thesis. Within Emden’s approach to creating core stories as

the basis for narrative analysis, 'story' is taken to signify 'a single narration or account that provides meaning to past events and actions of a person's life.... 'true' or imagined' (Emden, 1998, p35, after Polkinghorne, 1988).

The decision to develop 'core stories' as part of this research arose from a dilemma as to whether to present full transcripts of the ten interviews as part of this thesis, or to develop instead a summary of each account that, with more economy of word count, could be located as an appendix to the thesis. It was concluded that inclusion of one the women's stories was an important element of the analysis and writing up of this research, in order to demonstrate how the process of working with the interview material was enacted. However, it was decided that it would not be appropriate to include all ten core stories, even as an appendix, given the importance of seeking to preserve the anonymity of the respondents (the one core story in appendix 7 has been used following receipt of consent from the woman concerned). Emden's approach to narrative analysis (after Polkinghorne, 1988; and Mishler, 1986) was selected for its focus on reducing full length stories to shorter stories to aid the narrative analytical process, and thus to enable the revelation of different standpoints, dilemmas and themes within the accounts.

Emden developed her 'core story creation' approach by drawing on the work of Polkinghorne (1988) and Mishler (1986) and seeking to 'retain a greater sense of the whole story' (Emden, 1998, p35). The stages that she developed for creating core stories were as follows:

- 1) Reading the full interview text several times within an extended time-frame to grasp its content.
- 2) Deleting all interviewer comments and questions from the full interview text.
- 3) Deleting all words that detract from the key idea of each sentence or group of sentences uttered by the respondent.
- 4) Reading the remaining text for sense.
- 5) Repeating steps three and four several times, until satisfied that all key ideas are retained and extraneous content eliminated, returning to the full text as often as necessary for rechecking.
- 6) Identifying fragments of constituent themes (sub-plots) from the ideas within the text.
- 7) Moving fragments of themes together to create one coherent core story, or series of core stories.
- 8) Returning the core story to the respondent and asking ‘does it ring true?’ and ‘do you wish to correct/develop/delete any part?’

In preparing the ten core stories (an example of which is presented in appendix 7), steps 1-7 were followed, but it was decided not to return the stories to the

respondents. This was for two reasons. Firstly, this had not been indicated to respondents at the time of the interviews, nor had it been suggested in the application for ethical review. Secondly, There was a desire to avoid what Sandelowski has identified as the risk of research participants engaging in revisionism and changing their story ‘from one telling to the next’ (Sandelowski, 1993, p4). Sandelowski explains what she sees as the folly in linking validity with a perception of reality as follows:

‘the idea of empirically validating the information in one story against the information in another for consistency is completely alien to the concept of narrative truth and to the temporality, liminality, and meaning-making function of stories’ (op cit, p4).

It is recognised that the decision not to pursue member validation of the stories was a moral one, and that others might take a different view in the same situation. However, it was felt that the stories (as collected in tape recordings and in contemporaneous notes taken by the researcher) should stand as diverse and individual accounts given at a particular point in time, subsequently interpreted and re-presented by the researcher, taking account of the reflexivity that is explored later in this chapter. As Emden comments:

‘Provided narrative researchers remain faithful to their interest in the potential of stories to give meaning to people’s lives, the range of possible influences and strategies employed is vast, as are the consequential issues and dilemmas likely to arise....narrative inquiry is an expanding endeavour that does not lend itself to methodological constraint within research texts. Indeed, the spirit of narrative inquiry is perhaps best nurtured by a mature appreciation of multiplicity and difference’ (Emden, 1998, p39).

Exploring the core stories

Once the core stories had been created, they were analysed as a collective of stories, using the overarching pluralistic conceptual framework that was, as explained earlier in this chapter, rooted in a dialogical approach and closely related to Kondo's work that regards storytelling as providing a rich source of performances of multiply crafted selves. Within this focus on the presentation and (re)construction of multiple selves, analysis of the chief executives' stories was based on Grey's concept of the career as a project of self-management that in turn imposes a certain disciplinary control within the workplace. When examining the stories as texts, Ford's contradictory discourses (professional career, social and family, macho-management, postheroic leadership) were used as a way of mapping the tensions expressed, relating such tensions to the women's multiple and differing world views within a dialogical approach to leadership research (e.g. as mother, leader, manager, sister), and enabling the distillation of a set of common themes within the wider community of stories. When examining the responses of the women to the tensions with which they were faced, Collinson's work on insecurity in the workplace, and his assertion of the typical responses as being conformism, resistance and dramaturgy, were applied to each story.

Thus the analysis was carried out by reading and re-reading the core stories, and highlighting and then coding what were deemed to be the different standpoints taken by the women. These standpoints were then explored further as specific themes emerging within the stories, namely as unifiers of meaning from the different strands of reported experience (after DeSantis and Urgarriza, 2000).

Subsequent analysis of the themes within the wider literature (e.g. regarding the role of sponsors within career management, discrimination in the workplace, ascription of career success to luck) revealed that rather than themes, what had emerged was a set of dilemmas (or in Ford et al's [2008] terms, anxieties) experienced by the women as they constructed and chose to present certain selves within their stories. These dilemmas are explored in detail in chapter 6 of this thesis (hearing the stories of the women chief executives), and their implications are discussed within chapter 7 (discussion).

Reflexivity of the researcher within this study

As noted in chapter 1 (introduction), a fundamental authorial dilemma faced in writing this thesis was concerned with choosing what to present (or not present) of my own story of career and self. This dilemma is one crucially concerned with reflexivity, and the extent to which I as a researcher have shaped and been shaped by the research. As explained in chapter 1, the story of this research could be argued to be one of my deciding to study 'what I chose not to become', that is a woman chief executive in the NHS. This does however presuppose a sovereign authorial self who can choose what to be or not to be, and which seems at odds with the narrative analytical approach used in this research as a way of revealing multiple 'presences' or selves within the women's (and arguably therefore within my own) account.

Throughout the process of narrative analysis and subsequent preparation of this thesis, I have struggled to determine whether I am working with each woman's 'crafted self' or rather the representation by a woman of a number of 'crafted selves'. I recognise that as someone raised within the Christian faith I have a tendency to be attracted

towards the concept of a single and unified self, yet at the same time drawing on existentialist thought that considers each person the object in relation to the Foucauldian 'gaze' of others, endlessly required to create projects as a source of identity and meaning.

This paradox is however central to social constructionist thinking, for whilst the construction of multiple selves is fundamental to the process 'identity work', so it can be argued that a core part of narrative psychology is the use of narrative to cohere and unify the human self (Crossley, 2000). The fact that I struggled with the notion of multiple as opposed to single selves, and found myself drawn to the idea of 'crafting of selves' (and by implication into something more 'whole') within identity work, probably reveals something of my own story and reflexive presence within this research.

Patton (2002) suggested that reflexivity is 'to take an ongoing examination of *what I know* and *how I know it*' (p64). He went on to note that reflexivity 'has entered the qualitative lexicon as a way of emphasizing the importance of self-awareness, political/cultural consciousness, and ownership of one's perspective' (p64). Furthermore, Patton asserted that being reflexive involved self-questioning and self-understanding, and used the words of Schwandt (1997, p xvi) 'all understanding is self-understanding'.

Thus it can be concluded that qualitative researchers (and indeed quantitative researchers) should be attentive to and conscious of their own perspectives and voice, in particular the social, cultural, political, linguistic, and ideological origins of those

perspectives. This attentiveness to one's own perspectives as a researcher needs to be in addition to and in parallel to a focus on and attention to the perspective and voices of the people who are interviewed and whose narratives are recorded and analysed (Patton, 2002).

Hertz (1997) urged researchers to be aware of their own positions and to situate themselves explicitly within their research, arguing that researchers are:

‘imposed at all stages of the research process – from the questions they ask to those they ignore, from who they study to who they ignore, from problem formulation to analysis, representation and writing’ (1997, p viii).

Finlay (2002), drawing on Banister et al (1994), points out that it can be argued that reflexivity is now the defining feature of qualitative research. She notes:

‘Most qualitative researchers...will try to make explicit how inter-subjective elements impact on data collection and analysis in an effort to enhance the trustworthiness, transparency and accountability of their research’ (pp211-212).

It is in order to try and enhance the integrity of my analysis and presentation of this research that I acknowledge, explore and seek to understand my own reflexivity within this study.

Thus for this study, it was important for me to set out something of my own story and history right at the outset of the thesis (see chapter 1). The fact that I was a female NHS management trainee, a health services manager who was on a supposed fast-track to being a chief executive, and yet one who in 1995 stepped off that track to develop a role as a health policy and management researcher, was important context to the approach that I have taken to this study. This study reflects not only an analysis of the accounts of ten women chief executives, it is also a narrative of the self or

selves of Judith Smith, as well as a study that explores others' (the ten chief executives') narratives of self and selves, and how those were co-constructed within a dialogue between Judith and each chief executive. In exploring how the chief executives craft their selves within a narrative account, Judith Smith is present, having instigated, guided, recorded, transcribed, analysed and written up these crafted selves. Caution again needs to be expressed about regarding the authorial presence as somehow sovereign and unified – Judith Smith has arguably been influenced, shaped and narrated in new ways through the process of this research, just as much as she might have played some role in shaping the reported identity work of the ten women chief executives.

Finlay goes on to talk about the 'swamp' that has to be negotiated by qualitative researchers given that 'engaging in reflexivity is perilous, full of muddy ambiguity and multiple trails' (p212). She offers five 'maps through the swamp' that might be followed by what she terms 'researcher-explorers':

1. Introspection (using personal revelation not as an end in itself, but as a springboard for interpretations and more general insight).
2. Intersubjective reflection (exploring the co-constituted nature of the research looking at both inward meanings and outward into the realm of shared meanings, interaction and discourse).
3. Mutual collaboration (research participants as co-researchers, including reflexive dialogue during data analysis or evaluation).

4. Social critique (the use of experiential accounts whilst situating them within a strong theoretical framework about the social construction of power).
5. Discursive deconstruction (attending to the ambiguity of meanings in language used and how this impacts on modes of presentation).

In this study, I believe that the second map ‘reflexivity as intersubjective reflection’ and (to a lesser extent) the fifth map ‘reflexivity as discursive deconstruction’ best reflect how I have made my way through the process of addressing my reflexivity in relation to the research. Indeed, intersubjectivity is a core element of the dialogical approach as explored by Ford et al in their recent book (2008) exploring identity as leadership, and that interplay of the researcher and the respondents (and the co-creation of selves) is embedded within the narrative analytical and core story approach used in the analysis of data within this research.

Reflexivity as intersubjective reflection

Finlay refers to intersubjective reflection as where ‘researchers focus on the situated and negotiated nature of the research encounter and...how unconscious processes structure relations between the researcher and participant’ (Finlay, 2002, p215). She draws upon the work of Sartre and Beauvoir (as I did in my studies in the 1980s and again in approaching the narrative analysis within this research) to explore the ‘self-in-relation-to-others’ as both aim and object of focus.

When carrying out this study, and in particular when undertaking interviews with women chief executives, I was situated as a number of different and parallel selves (and these varied depending on whether or not, and how, I was known to the participant) within the interview encounter:

- *researcher* (all knew this due to the arrangements for the interview and purpose of the meeting);
- *academic from the Health Services Management Centre (HSMC)* (some of the participants had been on programmes at HSMC and/or knew colleagues there, and referred to this in small talk before and after interviews);
- *Nottingham peer* (in two cases, based on my accent and small talk before or after the interview, it emerged that I, like two of the chief executives, was born and brought up in Nottingham, in one case in the same suburb as the chief executive and at exactly the same time period);
- *management training scheme peer* (two of the participants knew that I had been a national NHS management trainee at the same time as them, a number knew that we had friends in common from the NHS management world and referred to this);
- *NHS Women's Register peer* (one chief executive recalled that we had both been on the NHS senior women's register in the 1990s and had attended a development centre together);

- *working mother* (a number of the chief executives referred to how I, like them, was balancing professional life with my role as a mother); and
- *teacher and supervisor* (one chief executive had been a student of mine when taking time out for a sabbatical, and I had supervised her dissertation – she referred to this, and to the fact she knew about my first child being born at this time, another knew me from my role as a tutor on the NHS Management Training Scheme when she had been mentor to some of the trainees).

These connections and positions were present to varying degrees in the interviews with the chief executives. Thus the research relationship itself was a factor in the overall crafting of narratives of self – in Sartre and Beauvoir’s terms, both I and the chief executive was interacting as ‘self-in-relation-to-other’. Whilst I have highlighted above the conscious and evident nature of elements of my reflexivity in relation to the research subjects, these different selves (of Judith Smith) were also present in those interviews where connections were not explicitly made – I was still a former NHS management trainee and manager, a working mother, and so on, even when this was not declared. Finlay asserts that to gain access to such complex personal (and possibly unconscious) motivations and dynamics, ‘a superhuman self-consciousness’ would be required, this being ‘attainable only through intensive psychoanalysis’ (op cit, p218). It seems therefore that in relation to intersubjective reflexivity, what is important is to acknowledge its presence within the research encounter and subsequent analysis, and to surface and explore areas where this reflexivity appears to have impact on interpretation and presentation of conclusions.

Reflexivity as discursive deconstruction

Finlay explains 'reflexivity as discursive deconstruction' as being when attention is paid to the ambiguity of meanings in language, and how this impacts on modes of presentation (Finlay, 2002). This is concerned with how researchers seek to pin down and represent the multiple meanings embedded in language. The reflexivity is present in the researcher's interpretation and presentation of the language used by participants, in the inferences drawn from use of language, the connections made within and across narratives, and the assumptions made when reaching conclusions based on the narrative accounts.

In this study, I have used ten accounts by women of being a chief executive in the NHS as the basis for carrying out a narrative analysis of accounts given by ten women chief executives in the NHS in late 2006. My working title for this element of the study 'gendered stories of leadership in difficult times', highlights my interpretation of the set of accounts as being concerned both with gender, and also located within a specific organisational context that appeared to influence and shape the language used and stories told. As narrative analysis within a primarily dialogical approach was used for the interpretation of the chief executives' stories, this entailed the exploration of dialogue (the narratives), the discerning of themes within the narratives, and an examination of discourses (connections between language used and the social world) revealed within the ten stories. As a researcher, I approached the texts in a necessarily reflexive way, bringing to my reading, interpretation, and analysis my own experience, ideology, upbringing, work experience, and so on.

Finlay concludes her exploration of reflexivity as discursive deconstruction as follows:

‘Post-modern researchers employing reflexivity to deconstruct have the opportunity to be creative and powerfully thought provoking if they find a balance so as not to lose all meaning’ (Finlay, 2002, p224).

It is my hope that my acknowledgement of and attentiveness to reflexivity within the process of collecting, analysing and presenting the data from this study will have surfaced themes and messages that are both creative and thought provoking.

Reflections on the methods used in this research

This study comprised two main sources of data collection: a postal survey questionnaire sent to all chief executives of NHS organisations in England in 2003 and again in 2006; and a set of in-depth interviews with ten women chief executives in the NHS in 2006/7. The survey questionnaire was designed in order to map the population of NHS chief executives and to test out initial areas of interest about issues such as the gender, age, career background, and current posts of this population.

Analysis of the results of the 2003 survey enabled the creation of an overall profile of NHS chief executives, and of comparisons between categories such as NHS trust/primary care trust, men/women, and first chief executive post/subsequent chief executive post. This analysis, supported by review of the literature about the key themes to have emerged, in particular about the role of gender in management and leadership, resulted in the decision to focus on in-depth exploration of the experiences of women chief executives in the second phase of the research.

Having provided vital context to the research, the survey questionnaire was repeated in 2006 in order to update this context, especially as it was known that the NHS organisational map had altered in the face of a very recent national structural reorganisation. This confirmed that women continued to be a minority group overall within the NHS chief executive community and that NHS trusts were less likely to have a woman leader than were PCTs. The decision to focus on the experience of women chief executives for the qualitative and in-depth phase of the research was thus felt to be justified, given the relative lack of exploration of such experiences in the literature of health care management and leadership.

In drawing conclusions from the research, analysis of the ten core stories resulted in the identification of six dilemmas that shed light on the experiences of senior women managers in the NHS in England. In the discussion section of this thesis (chapter 7), these dilemmas are explored in relation to the wider literature and research on those topics, and in the context of the population of NHS chief executives as described through the two surveys carried out within this research.

Reflecting on the methods used in this research, it is clear that the survey questionnaire enabled a positivist description of the population of NHS chief executives, and the highlighting of key features in the PCT and NHS trust sub-populations respectively. In turn, this element of the research served a functionalist purpose by highlighting key areas for further exploration in the second phase of the research, of which gender was selected as the primary focus. The survey was similarly useful as a tool for updating the population profile of chief executives in 2006, and again secured a healthy (if not as high as 2003) response rate. However,

given that the survey was designed explicitly to be completed within ten minutes, and hence with the hope of a high response rate, it was limited in its scope and had to be restricted to basic demographic information, and did not extend to more in-depth questions about chief executives' aspirations, concerns, and so forth.

The interview phase of the study provided in-depth and privileged access to the stories and experiences of ten women chief executives, and reflected the overarching theoretical interest in a pluralistic and primarily dialogical approach that explored the constitutive nature of self (or selves) as revealed through language in co-constructed encounters between researcher and respondent. Despite the requests for interviews being sent out at a time when the NHS was facing major structural reorganisation, chief executives were generous in responding positively and in offering their time to be interviewed. Indeed, more chief executives responded than were in fact needed for the sample. Similarly, no chief executive cancelled their interview, something that had been anticipated as a potential issue, given the busy time of year (early winter) and the pressing priorities typically faced by senior executives. This was taken to indicate the interest and enthusiasm felt by the chief executives about the research, something that many of them commented on informally before or after the interview itself.

The writing up of reflections on each interview by the researcher proved to be very useful as a further indicator of the context to each interview, and enabled a further element of reflexivity within what was in any case arguably 'research into what Judith Smith chose not to become'. These notes captured the researcher's impressions and responses to the location of the interview, factors such as the office, welcome given,

and atmosphere, and also enabled a summary to be made of conversations that typically took place for a period of time after the taping of the 'formal interview' had ceased.

The interviews were carried out over a relatively short period of time (just seven weeks in total) and as such represented an intensive research experience captured in tape recordings of the discussions, contemporaneous notes, and the written reflections referred to above. As a group of interviews, they enabled the collection of ten stories of what it felt like to be a woman chief executive in the NHS in late 2006. What was not possible, however, was to determine how far these stories and experiences were similar to or different from the stories that would have been told by men in the same situation.

The decision to focus on the accounts of women was taken as a response to what emerged from the postal questionnaire about the apparently distinctive position of women within the chief executive population. In addition, it was decided that a focused exploration of women's experiences was what was primarily sought as an end in itself, rather than an analysis that drew comparisons with men. Given what is referred to in the critical management studies and feminist literature as the 'masculine-dominated world' of new public management (Learmonth, 2004 p14, after Davies, 1995), it was felt inappropriate to explore women's experiences in comparison with that of men, focusing instead on women's stories as the core resource for analysis. Interestingly, two of the women interviewed for the research challenged this decision to focus exclusively on women, either within their interview or during informal discussion once the tape had been turned off. It was asserted to the

researcher that it would be interesting to develop further the analysis of women's stories by making comparisons with the accounts made by men.

The ten interviews provided a large amount of data for analysis – over 15 hours of tape recordings which were listened to and transcribed by the researcher. The initial intention had been to contract out transcription, but once the interviews had been carried out, it became apparent that immersion and re-immersion into the stories was critical to analysis of the individual and collective stories, and hence the revised decision to carry out transcription as a direct part of the analytical process.

The analysis of the ten stories involved an iterative process of reading each story, identifying discourses and themes, coding these, and then continuing with the next story, continually building up a fund of discourses and themes. This was the most time-consuming and complex stage in the overall research project, calling for many hours of reading, thinking, coding, re-coding, and writing. The core challenge to this process of analysis was when and how to call a halt, and to consider that sufficient insights had been drawn from a rich fund of data.

Once a matrix of discourses and themes had been developed for each individual chief executive account, a further process of analysis was undertaken across the set of stories. This took place on both an individual basis with the researcher making her own analysis of what appeared to be the common dilemmas (originally explored as paradoxes) expressed by the women, and on a collaborative basis in discussion with supervisors. This process resulted in an initial set of eight paradoxes which was subsequently refined to six dilemmas following extensive discussion within

supervision sessions, and reflections on the literature associated with the themes underpinning these dilemmas.

The final decision to frame the tensions within the narrative accounts as ‘dilemmas’ was based on a sense by the researcher of some uncertainty about the tensions experienced, and a sense of an expectation of some action in response to the perceived tension or disconnect. There was a troubling aspect to them that made them stronger than ‘paradoxes’, and lent them an edge of discomfort and concern, something that Ford et al (2008) echo in their assertion of ‘anxieties’ within the data they analysed relating to accounts of the experience of leadership within local authority organisations. Once explored within the presentation and discussion of research findings, the set of six dilemmas felt congruent with the sense the researcher had felt within the interviews of women facing troubling challenges in relation to their different selves and roles. Thus the overall research synthesis is framed within these six dilemmas which are considered to give an insight into these gendered stories of leadership in difficult times.

The methods employed in this research have been evolutionary, the initial survey leading to a phase of in-depth story collection, transcription of the stories leading to a process of narrative analysis. The study started out as an assessment of the role of chief executives of primary care organisations and ended up as an exploration of the stories told by women chief executives in the NHS. From an initial inquisitiveness about the nature of the population of chief executives in PCTs, new organisations emerging in the NHS in 2000, a research process developed that led towards a focus on gender within health care leadership and management. This shift towards gender

was reflexive in that it bore witness to the researcher's own interests and world view, and inductive in that it arose from the findings of the initial quantitative survey.

This research has adopted an explicitly emergent approach to its methods, viewing the process as a journey whose end was not evident at the start, but that evolved as the route unfolded. A shift occurred between the two main phases of study, from a more positivist or functionalist approach that was associated with comparing health sectors in relation to their management community, to another focused on a more pluralistic and primarily dialogical theoretical perspective of leadership with health organisations, supplemented by elements of critical and constructivist discourse within the analysis of in-depth interviews with women chief executives. What has emerged is a set of gendered stories of leadership in difficult times, stories that reveal through narrative analysis a rich picture of shifting and multiple selves under construction.

Chapter summary

This chapter has set out an account of the methods used in order to try and answer the questions developed at the outset of this research and again at the start of the second phase of study. The pluralistic theoretical approach to the research informed the selection of narrative analytical methods used to analyse data from the study, and given the primarily dialogical discourse that underpinned the research, it is unsurprising that the women chief executives' stories were explored as the presentation of multiple and shifting selves. The supplementary use of critical and constructivist lenses to approach the data is evident in the examination of the

women's stories as being 'gendered', reflecting the 'career as a project of self-management', and 'performative' and co-constructed in nature.

In the chapters that follow, data from the two main stages of the research are presented. Firstly, the results of the two survey questionnaires that sought to map the chief executive population of the NHS in England, and secondly, the dilemmas revealed during narrative analysis of stories of career told to the researcher by ten women chief executives.

CHAPTER 5

MAPPING THE CONTEXT: NATIONAL SURVEY OF NHS

CHIEF EXECUTIVES

Introduction

The initial research question for this study was: who are the chief executives of primary care trusts in England, and in what ways, if any, do they differ from the population of chief executives of NHS trusts? The area of interest concerned how far the population of PCT chief executives differed from the population of NHS chief executives in NHS trusts. Possible areas of difference were deemed to include:

- gender – an assumption that a greater percentage of PCT chief executives were women, in comparison with NHS trust chief executives;
- age – an assumption that a greater percentage of PCT chief executives were younger, compared with their NHS trust counterparts;
- chief executive experience – an assumption that a greater percentage of PCT chief executives were in their substantive first chief executive post.

In order to establish whether or not PCT chief executives as a group did differ from the wider population of NHS chief executives, and to ascertain whether there was any basis to the above assumptions, it was necessary to establish the profile of the population of the PCT chief executives. There was also a need to determine the population profile of comparator NHS trust chief executives, and thus paint a

complete picture of the NHS chief executive community in England. To achieve these objectives, a national postal questionnaire survey of NHS chief executives was carried out in England in 2003 and then repeated for follow-up purposes in 2006.

2002 pilot survey of NHS chief executives in Scotland

An initial pilot study of the survey questionnaire was carried out in Scotland. In preparing the questionnaire for this study of the chief executive population, a review of similar previous studies of NHS senior managers was undertaken, including the Career Paths study carried out for the NHS Executive in 1994 (IHSM Consultants, 1994), Dixon and Shaw's 1986 study of the career paths of national administrative trainees, and the Templeton study of district general managers in the late 1980s (Dopson et al, 1987a-e) (see chapter 3 literature review for more details of these studies).

It was deemed important to examine previous studies in order to establish what data chief executives had been asked to provide in response to questionnaires, to consider what conclusions researchers had been able to draw from such data, and to design the questionnaire for this study in such a way that comparisons with former studies from the 1980s and 1990s would be possible. This review led to the conclusion that there was a need to collect a core set of information from all PCT and NHS trust chief executives, covering the following areas:

- job title;
- length of time in post;
- employment status (e.g. full or part time);

- salary range;
- immediate employment history;
- personal data (age, gender, ethnic origin, disability status, educational qualifications, professional qualifications);
- type of organisation;
- services provided;
- budget;
- headcount of employed staff; and
- date of establishment of organisation.

The questionnaire was designed in order to be easily completed within ten minutes by chief executives. This was based on the assumption that chief executives are busy people in pressurised posts and with little time for administrative tasks. The questionnaire also had questions that required a simple ‘tick box’ response where possible. There were 16 questions, organised into the following themes:

Your organisation

- type of organisation;
- service provided;
- total revenue budget;
- number of people employed; and
- date of establishment of organisation.

Personal information

- date of taking up current post;

- employment status;
- basic gross salary;
- job immediately prior to this post (title, organisation, salary);
- gender;
- age;
- ethnic origin;
- disability status;
- highest educational qualifications;
- professional qualifications; and
- anything else to add.

A copy of the pilot survey questionnaire is attached at appendix 8.

In July 2002, the pilot survey questionnaire was sent to all chief executives of NHS trusts and primary care trusts in Scotland (n=28). The initial mailing resulted in 20 responses and a further 4 were received following the sending of a chaser letter one month after the initial mailing. The total response to the survey was 24, representing a response rate of 85.7%. Of the 24 respondents, 11 were from chief executives of NHS trusts and 12 from primary care trust (PCT) chief executives. One survey was returned by a chief executive from a combined NHS trust/PCT. Of the four non-responders, two were from NHS trusts and two from PCTs.

It should be noted that in 2002, PCTs in Scotland were constituted in a different way from their namesakes in England, being largely service provider bodies, and not carrying out the commissioning of secondary care services. In many ways, they were

more like former community trusts in the English NHS, with additional responsibilities in respect of support for and development of primary care (general medical practice, dentistry, pharmacy and optometry). This issue of 'Scottish difference' was noted by a number of respondents on their completed questionnaires, when asked to comment on how they had found the survey. No other comments were made in relation to issues about completion of the survey questionnaire, despite a question that invited feedback to aid the preparation of the subsequent (main) survey in England.

Numbers in the pilot survey sample were small, such is the nature of the Scottish health system and its organisational structure. Nevertheless, the results of the survey painted a picture of the chief executive population in the NHS in Scotland in 2002. It should be noted that the response rate for the survey was high at 85.7%, hence even if the non-responders differed from the main population in respect of gender, race and so forth, it would be unlikely to change the general overall picture found in the pilot study.

The overall impression gained was of a homogenous population of chief executives within the NHS in Scotland, and of a community of managers that lacked diversity. Just 12.5% of chief executives were women, and there were no chief executives reporting an ethnic origin other than white European. No chief executive reported being registered as disabled, and no chief executive who worked less than full-time. In terms of age, 83.3% of Scottish NHS chief executives were aged between 40 and 54. All except one of the chief executives responding to the survey had come to their

post from a prior position in an NHS trust or PCT, again suggesting a very consistent and conservative pattern of recruitment to NHS senior management in Scotland.

There are a number of factors that might explain the make-up of this population of chief executives in Scotland. Firstly, as noted earlier, NHS organisation in Scotland has, since devolution in 1999, differed from that of the English NHS, meaning that a 'PCT' was not the same form of organisation as its English counterpart. Secondly, the much smaller scale of the Scottish NHS might make for a more cohesive and homogenous population of chief executives. Similarly, it could be that chief executives in Scotland tend to remain in the Scottish health system, and this might explain the lack of diversity of career paths and other demographic features. From this survey questionnaire, it was not possible to tell whether prior posts were in Scotland or elsewhere, and data were not sought about posts earlier on in the chief executives' careers.

Thirdly, the findings pointed to a need to establish why it was that women appeared in 2002 to have largely failed to be appointed to NHS chief executive posts in Scotland. Although the English NHS in 2003 shared Scotland's lack of chief executive diversity in respect of race, disability, age and employment status, there was a significantly different picture in relation to gender, with 39.4% of NHS chief executives in England being women (50% in PCTs), compared with 12.5% in Scotland.

Fourthly, it should be borne in mind that this study did not survey health board chief executives in Scotland (the purchasing/funding agencies in 2002), and nor did the 2003 English survey include strategic health authority chief executives. Given that

health boards in Scotland carried out many of the functions of a PCT in England, it would have perhaps aided comparisons if that cohort had been included in the study.

In conclusion, the pilot phase of the NHS chief executive survey revealed that the NHS chief executive community in Scotland in 2002 was essentially homogenous, being overwhelmingly male, white and aged 40-54. This raises important issues about the development of more diverse management capacity within Scotland, and how opportunities might be extended to people aspiring to be NHS senior managers who do not conform to a traditional white male stereotype of leadership.

For the purposes of this research, however, the pilot study revealed that the questionnaire was apparently attractive to chief executives in terms of its format and content, and likely to elicit a high response rate. The lack of suggestions by the respondents in relation to improving or changing the questionnaire, along with the revelation of interesting findings about the profile of NHS chief executives in Scotland, led to a belief that the overall structure and content of the questionnaire was appropriate to the research questions being examined, and hence could be used unaltered for the main survey of chief executives in England.

2003 survey of NHS chief executives in England

Following completion of the pilot phase of the study in 2002, the confirmed survey questionnaire was sent to all 300 NHS trust and 304 PCT chief executives in England in April 2003. The purpose of the survey was as follows:

- to collect factual data about NHS trust and PCT chief executives;

- to use these data as a basis for describing the population of the two categories of chief executive of relevance to this research, namely those in NHS trusts and those in PCTs;
- to be able to determine to what extent, if any, chief executives of PCTs differed from the wider population of NHS chief executives; and
- to have sufficient baseline data to determine the focus and nature of the second phase of the study.

A copy of the survey questionnaire is at appendix 9. A copy of the letter that was sent to the chief executives along with the questionnaire is at appendix 10. The initial mailing in April 2003 to all trust and PCT chief executives in England (n=578) resulted in 348 responses and a further 103 were received following the sending of a chaser letter in May 2003, four weeks after the date of the original mailing of the survey. The total response to the survey was 451, representing an overall response rate of 78%. Of the 451 respondents, 206 were from chief executives of NHS trusts (68.7% response rate) and 242 from primary care trust (PCT) chief executives (79.6% response rate). Three were from care trust chief executives, care trusts being organisations that bring together health and social services into a single body (as opposed to having a PCT for community health services whilst social services are within the local authority).

2006 survey of NHS chief executives in England

A follow-up survey was carried out in November 2006, with the intention of updating the 2003 national profile of NHS chief executives. Of interest was an examination of any changes to the national chief executive profile over time, in particular what had happened to the PCT chief executive population as a result of the 2006 reorganisation of PCTs into larger bodies. A further change that was of interest was the establishment of NHS foundation trusts from April 2004 onwards, and this was included as a specific organisational category in the 2006 survey. November 2006 was chosen on account of October 2006 being the month for the start of ‘new’ reconfigured PCTs, following the implementation of reforms announced in *Commissioning a Patient-Led NHS* (Department of Health, 2005a).

All NHS chief executives of NHS trusts and PCTs in England were again surveyed (n=403), using publicly available records of their job roles and addresses. Each chief executive was written to by the principal investigator, inviting them to complete and return the questionnaire, explaining the overall purpose of the study, setting out a brief summary of findings from stage one research, and telling them how they will receive information about overall project findings at the conclusion of the study. A copy of this letter is at appendix 11.

The survey questionnaire from 2003 was used in 2006, with minor modifications – a copy of the revised version is enclosed at Appendix 12. These modifications were as follows:

- inclusion of NHS foundation trusts as an organisational category, given that these were new organisations now in place in the NHS in England;
- inclusion of ‘consider yourself to be disabled’ in addition to ‘registered disabled’ as a category for identifying disability status, following advice from peer review of the questionnaire; and
- revision of the salary categories in order to recognise overall inflation of salaries and to ensure capture of bandings of salaries at the higher end of the scale.

The overall intention of the 2006 survey was to update the demographic profile of NHS chief executives in England and to identify and report any changes as part of the overall study conclusions. The questionnaire once again sought to describe the population of NHS chief executives in terms of its demography, and to draw comparisons with the population of NHS chief executives. More specifically, its purpose was:

- to collect factual data about NHS trust, foundation trust, care trust and PCT chief executives;
- to use these data as a basis for describing the population of each category of chief executives;

- to be able to determine to what extent, if any, the nature of the two populations has changed over the period 2003-2006;
- to be able to draw conclusions about the profile of the NHS chief executive population and in particular about the differences between the two main categories; and
- to provide the backdrop to the detailed analysis of gender in health services management that was the main focus of the semi-structured interviews with female chief executives in the second stage of the research.

In November 2006, as in 2003, non-responders received a follow-up letter and copy of the questionnaire one month after the initial mailing of the survey. Following a time lapse of one further month, the survey response was considered to have been completed.

The initial mailing in 2006 resulted in 172 responses and a further 78 were received following the sending of a chaser letter. The total response to the survey was 250, representing a response rate of 62%. This compares with a response rate of 78% in May 2003. Of the 250 respondents, 129 were from chief executives of NHS trusts, 32 from NHS foundation trusts (total trust response rate of 64.9%) and 85 from primary care trust (PCT) chief executives. Four were from care trust chief executives (total PCT and care trust response rate of 60.5%).

Whereas in 2003 the response rate for PCT chief executives was higher than that for trust chief executives, this was reversed in 2006, with 60.5% PCT chief executives (PCT and care trust) and 64.9% trust (NHS trust and NHS foundation trust) chief executives responding. It is possible that the lower response rate within PCTs was due to the significant organisational turmoil that was happening in the NHS in the second half of 2006, when a majority of PCTs (and not NHS trusts) were being restructured and reconfigured, and in some cases (as was ascertained from responses received from ten PCTs who wrote back saying that could not complete the survey) there was no chief executive in post.

Data gathered in both surveys (2003 and 2006) were inputted into a database and analysed using descriptive statistical techniques, including cross-tabulations and pivot tables.

Statistical testing was performed in order to detect differences between the 2003 and 2006 data sets. A two-sample z-test for equality of proportions with a continuity correction was used in order to compare the proportions from the two samples. The test assumes equality between proportions from the two data sets and then works out the probability of seeing a difference as large, or larger than, we did. This probability is called a p-value and by convention, a p-value of less than 0.05 indicates a significant difference between proportions from the two data sets. Therefore, all tests that had p-value less than 0.05 were deemed to be significant.

The results of the two surveys are reported in the following sections of this chapter.

Findings of the 2003 and 2006 chief executive surveys

a) Gender

The gender split among chief executives in 2003 is set out in table 5.1 below:

Table 5.1: gender of NHS chief executives in England in 2003

	NHS trusts	PCTs	Care trusts	Total chief executives
Males	149 (72.3%)	121 (50.4%)	2 (66.6%)	272 (60.6%)
Females	57 (27.7%)	119 (49.6%)	1 (33.3%)	177 (39.4%)
Totals	206 (45.9%)	240 (53.5%)	3 (0.6%)	449 (100%)

The overall gender split in this sample of NHS chief executives in 2003 was one of 60:40, male:female. There was however an almost equal gender split in this sample population of PCT chief executives. In the sample of NHS trust chief executives, the gender split was different, with almost three quarters being male. The numbers for care trusts were too small to be significant.

In November 2006, the gender split among NHS chief executives was as set out in table 5.2 below.

Table 5.2: gender of NHS chief executives in England in 2006

	NHS trusts	NHS foundation trusts	PCTs	Care trusts	Total chief executives
Males	88 (69.3%)	26 (81.3%)	37 (45.7%)	2 (50%)	153 (62.7%)
Females	39 (30.7%)	6 (18.7%)	44 (54.3%)	2 (50%)	91 (37.3%)
Totals	127 (52%)	32 (13.1%)	81 (33.2%)	4 (1.6%)	244 (100%)

The overall gender split in this sample of NHS chief executives is one of 63:37, male:female. A two-sample z-test for equality of proportions with a continuity correction showed that the proportion of females was not significantly different between 2003 and 2006 ($p=0.6404$). Whereas the gender split in the sample population of PCT chief executives was equal in 2003, it is now weighted in favour of women, although the difference in proportions is not significant ($p=0.5426$). However, it should be recognised that the sample of PCT chief executives and the overall population, following major reorganisation of PCTs in 2006, was much smaller in 2006 (sample of 85 in 2006 compared with 242 in 2003). It should be noted that 85 (plus four care trusts, that the Department of Health regards as a form of PCT in their statistics) represents a sample of 60.5% of all PCTs in England, compared with a sample of 80.9% of PCTs and care trusts responding in 2003.

In the sample of NHS trust chief executives and foundation trust chief executives combined (there was no such distinction in 2003, hence for comparative purposes it makes sense to treat these as a single group), the gender split in 2006 continued to be different from PCT counterparts, with almost three quarters being male (71.7%). Although the numbers were small, it is of note that for NHS foundation trusts, over 80% of chief executives were male. The numbers for care trusts meant the data were too few to be analysed with reliability, and they have been treated as PCTs in the main analyses in this chapter.

Conclusion: The gender split in the chief executive population in 2006 (63:37 male:female) was much the same as in 2003, although it appeared that women had become the larger group within the PCT chief executive population.

In a study of unit general managers (UGMs) in 1986-87 (Disken et al, 1987), it was reported that whereas 17.3% UGMs were women, only 11.7% of acute unit UGMs were women. It was noted in that study that women were more likely to be UGMs of community, maternity or priority (mental illness/handicap [sic]) services. Thus it would seem that the propensity for women to work in community/non-acute services persists through to 2003 and 2006, despite an overall increase in the proportion of women chief executives.

Further analysis of the gender split of chief executives in 2003 in relation to size of organisation (as measured by budget), is set out in tables 5.3 (NHS trusts) and 5.4 (PCTs) below:

Table 5.3: gender of NHS chief executives in NHS trusts in England in 2003, by size of budget of organisation

Budget band	Male	Female	Total
Up to £50m	20	14	34
£51m - £100m	55	21	76
£101m - £150m	29	7	36
£151m - £200m	14	7	21
£201m - £250m	14	1	15
£251m - £300m	8	1	9
£301m +	5	0	5
Missing data	4	6	10
Total	149	57	206

This analysis of gender of NHS trust chief executives by size of budget of organisation shows that in 2003, men were more likely to be chief executives of large NHS organisations (as measured by size of budget) than women. Whereas 51.7% male chief executives responding to the question about organisation budget were in an organisation with budget of up to £100m (n=75 out of 145 responding), 68.6% women chief executives of NHS trusts reported being in an organisation with a budget

of up to £100m (n=35 out of 51 responding) (p=0.0629) Similarly, in relation to trusts with a large budget (£201m - £300m), 15.2% male chief executives were in this category (n=22 of 145 responding) (p=0.0629) compared with 3.9% women (n=2 of 51 responding). For NHS trusts with a budget of £301m or more, 3.5% men (n=5 of 145 responding) and no women were in this category.

Table 5.4: gender of NHS chief executives in PCTs in England in 2003, by size of budget of organisation

Budget banding	Male	Female	Total
Up to £50m	2	3	5
£51m - £100m	32	22	54
£101m - £150m	44	41	85
£151m - £200m	13	23	36
£201m - £250m	13	16	29
£251m - £300m	7	7	14
£301m +	5	2	7
Missing data	5	5	10
Total	121	119	240

Table 5.4 demonstrates that within PCTs, the gender split in relation to size of organisation (as measured by budget) is different from that of NHS trusts. Female PCT chief executives are slightly more likely than their male counterparts to work in a larger organisation. For example, 29.3% male PCT chief executives responding to the question about organisational budget (n=34 of 116 responding) reported that the budget of the PCT was up to £100m, compared with 21.9% female PCT chief executives (n=25 of 114 responding) (p=0.2583). Similarly for higher budget levels, there was no indication that women were any less likely than men to be in these categories (indeed they were slightly more likely to be in such organisations), as shown by the fact that 17.2% male PCT chief executives (n=20 of 116 responding) and 20.2% female PCT chief executives (n=23 of 114 responding) worked in organisations with a budget of £201m - £300m (p=0.688).

Further analysis of the gender split of chief executives in 2006 in relation to size of organisation (as measured by budget), is set out in tables 5.5 (NHS trusts) and 5.6 (PCTs) below:

Table 5.5: gender of NHS chief executives in NHS trusts in England in 2006, by size of budget of organisation

Budget band	Male	Female	Total
Up to £50m	0	2	2
£51m - £100m	19	11	30
£101m - £150m	20	12	32
£151m - £200m	21	8	29
£201m - £250m	6	2	8
£251m - £300m	9	2	11
£301m +	13	2	15
Missing data	0	0	0
Total	88	39	127

This analysis of gender of NHS trust chief executives by size of budget of organisation shows that in 2006, men continued to be more likely to be chief executives of large NHS organisations (as measured by size of budget) than women. Whereas 21.6% male chief executives responding to the question about organisation budget were in an organisation with budget of up to £100m (n=19 out of 88 responding), 33.3% women chief executives of NHS trusts reported being in an organisation with a budget of up to £100m (n=13 out of 39 responding) (p=0.2362). Similarly, in relation to trusts with a large budget (£201m - £300m), 17.0% male chief executives were in this category (n=15 of 88 responding) compared with 10.3% women (n=4 of 39 responding) (p=0.4717). For NHS trusts with a budget of £301m or more, 14.8% men (n=13 of 88 responding) and 5.1% women (n=2 of 39 responding) were in this category (p=0.2093, although small numbers require that this be treated with caution).

Table 5.6: gender of NHS chief executives in PCTs in England in 2006, by size of budget of organisation

Budget band	Male	Female	Total
Up to £200m	3	3	6
£201m - £300m	5	11	16
£301m - £400m	9	14	23
£401m - £500m	10	5	15
£501m - £700m	3	5	8
£701m +	6	3	9
Missing data	1	3	4
Total	37	44	81

Table 5.6 demonstrates that within PCTs in 2006, the gender split in relation to size of organisation (as measured by budget) continues to be different from that of NHS trusts. Female PCT chief executives are slightly more likely than their male counterparts to work in a larger organisation. For example, 8.1% male PCT chief executives responding to the question about organisational budget (n=3 of 37 responding) reported that the budget of the PCT was up to £200m, compared with 6.8% female PCT chief executives (n=3 of 44 responding). Similarly for higher budget levels, there was no indication that women were any less likely than men to be in these categories, as shown by the fact that 91.9% male PCT chief executives (n=34 of 37 responding) and 93.2% female PCT chief executives (n=41 of 44 responding) worked in organisations with a budget of £201m or more.

In 1981, 13% of chief officers in the NHS in England and Wales were women, and these were principally regional, district and area nursing officers (Dixon and De Metz, 1982). A study of unit general managers in 1986-87 (Disken et al, 1987) revealed that 17.3% of UGMs were women and 82.7% were men. The NHS Women's Unit Creative Career Paths Study of Top Managers (IHSM Consultants, 1994) reported that in their survey in 1993, 21% of top managers in England were women. Only 5% of respondents to the Creative Career Paths Survey from Scotland were women, a

differential with the English NHS that was confirmed again in 2002 when only 12% Scottish chief executives were women. The Creative Career Paths Study categorised ‘top managers’ as being chief executives of all NHS organisations, managers in the NHS Management Executive at Civil Service grade 5 or above, and operational directors in provider organisations who were accountable to the chief executive for the operational management of the unit. It seems therefore that there was an increase in the proportion of women chief executives/top managers in the NHS from 1993 to 2003, given that this 2003 study revealed that 39.4% of chief executives were female, and a potential levelling off this trend by 2006 when the follow-up phase of this research suggested that 37.3% of NHS chief executives were female.

b) Age

The age profile of chief executives in 2003 is set out in table 5.7 below:

Table 5.7: age profile of NHS chief executives in England in 2003, showing percentage of chief executives in each age group by organisation type and gender

Age band	NHS trusts male	NHS trusts female	PCTs male	PCTs female	All
<30	0	0	0	0	0
31-35	1 (0.5%)	0 (0%)	2 (0.8%)	0 (0%)	3 (0.7%)
36-39	5 (2.4%)	6 (2.9%)	8 (3.3%)	13 (5.4%)	32 (7.2%)
40-44	29 (14.1%)	17 (8.3%)	35 (14.6%)	40 (16.7%)	121 (27.1%)
45-49	54 (26.3%)	22 (10.7%)	39 (16.3%)	50 (20.8%)	165 (37.0%)
50-54	43 (21.0%)	9 (4.4%)	30 (12.5%)	13 (5.4%)	95 (21.3%)
55-59	16 (7.8%)	3 (1.5%)	7 (2.9%)	3 (1.3%)	29 (6.5%)
>60	1 (0.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Total	149	57	121	119	446

NB: Percentages shown for NHS trusts and PCTs are calculated on basis of total number of chief executives within the organisational type. Percentages for gender totals are calculated on the basis of total number of chief executives of that gender.

This table shows that in 2003 the majority (85.4%) of chief executives in the NHS were aged between 40 and 54. Within NHS trusts, 84.8% of chief executives were aged between 40 and 54, and in PCTs, 86.3% were within this age span ($p=0.6908$). However, a more detailed examination of the data reveals that the age profile of PCT chief executives in 2003 was overall younger than that of NHS trusts. Seventy-eight per cent of PCT chief executives were aged under 50, whereas 65.2% of NHS trust chief executives were in this age category ($p=0.0036$). The tendency of NHS trust chief executives to be older than their PCT colleagues was confirmed by an examination of those aged 55 and over – 9.8% of NHS trust chief executives and 4.2% of PCT chief executives ($p=0.01229$).

In relation to gender and age profile, in 2003, women chief executives were more likely to be younger than their male counterparts (10.7% of women chief executives were under 40 whereas 5.9% of men were in this category [$p=0.09122$]). Similarly, 84.1% of women chief executives were under 50, whereas 64.4% of men were under 50 ($p<0.0001$). Likewise, there was a greater percentage of men than women in the higher age brackets.

Conclusion, in 2003, chief executives of NHS trusts tended to be older than those of PCTs, and male chief executives tended to be older than their female counterparts.

The age profile of chief executives in 2006 is set out in table 5.8 below:

Table 5.8: age profile of NHS chief executives in England in 2006, showing percentage of chief executives in each age group by organisation type and gender

Age band	NHS trusts/FTs male	NHS trusts/FTs female	PCTs male	PCTs female	All
<30	0	0	0	0	0
31-35	0 (0%)	0 (0%)	0 (0%)	1 (1.2%)	1 (0.4%)
36-39	4 (2.5%)	1 (0.6%)	0 (0.0%)	1 (1.2%)	6 (2.5%)
40-44	14 (8.8%)	8 (5.0%)	8 (9.5%)	5 (6.0%)	35 (14.4%)
45-49	47 (29.6%)	16 (10.1%)	16 (19.0%)	20 (23.8%)	99 (40.7%)
50-54	29 (18.2%)	16 (10.1%)	11 (13.1%)	19 (22.6%)	75 (30.9%)
55-59	18 (11.3%)	3 (1.9%)	2 (2.4%)	0 (0%)	23 (9.5%)
>60	2 (1.3%)	1 (0.6%)	1 (1.2%)	0 (0%)	4 (1.6%)
Total	114	45	38	46	243

NB: Percentages shown for NHS trusts and PCTs are calculated on basis of total number of chief executives within the organisational type. Percentages for gender totals are calculated on the basis of total number of chief executives of that gender.

This table shows that the majority (86%) of chief executives in the NHS in 2006 were aged between 40 and 54. Within NHS trusts, 81.8% of chief executives were aged between 40 and 54, and in PCTs, 94% were within this age span ($p=0.01504$).

However, a more detailed examination of the data reveals that in 2006 the age profile of PCT chief executives was overall slightly younger than that of NHS trusts. Sixty-one per cent of PCT chief executives were aged under 50, whereas 56.6% of NHS trust chief executives were in this age category ($p=0.6306$). This was in contrast to the finding of 2003 where the population of PCT chief executives was clearly younger than that of NHS trusts. However, this difference may be in part explained by the lower response rate in 2006, especially for PCTs. The ongoing tendency of NHS trust chief executives to be older than their PCT colleagues is confirmed by an examination

of those aged 55 and over – 15.1% of NHS trust chief executives and 3.6% of PCT chief executives ($p=0.03326$).

In relation to gender and age profile, women chief executives in 2003 were more likely to be younger than their male counterparts (10.7% of women chief executives were under 40 whereas 5.9% of men were in this category). In 2006, there were too few chief executives under 40 to give reliable significance test results. However, even if the next category of 40-44 was included, percentages for men and women were almost equal (17 and 17.7% respectively [$p=1.0000$]). Similarly, 58.5% of men were under 50 and 57.1% of women chief executives were under 50, again suggesting that the 2003 gender difference related to age was no longer present in the chief executive population ($p=0.9353$). There were however a greater percentage of men than women in the higher age brackets (>55 , $p=0.01796$).

In 2006, chief executives of NHS trusts tended to be slightly older than those of PCTs when the highest age brackets were examined, but overall, age profiles for the two organisational types were now similar. Likewise, the gender difference that was detected in 2003 in relation to age of chief executive was no longer present in the chief executive population.

Conclusion: In 2006, there was no longer any significant age difference between the PCT and NHS trust chief executive populations, nor between genders. There were overall fewer younger chief executives, and the majority were aged 40-54.

c) *Salary*

The survey questionnaire asked chief executives to report their basic gross salary, full-time equivalent and exclusive of bonuses and performance awards. The data collected in response to this question in 2003 are set out in table 5.9 below. The table shows that NHS trusts had a much wider range of salaries than PCTs, covering the full range from less than £60,000 to in excess of £130,000. It should be noted that the three NHS trust chief executives reporting a salary of less than £60,000 worked in NHS ambulance trusts.

Table 5.9: basic gross salary of NHS chief executives by type of organisation, April 2003

	NHS trust male	NHS trust female	PCT male	PCT female	All
<£60,000	3	0	0	0	3
£60,000-£69,999	1	3	0	4	8
£70,000-£79,999	7	5	15	17	44
£80,000-£89,999	21	13	41	31	106
£90,000-£99,999	47	10	53	53	163
£100,000-£109,999	27	7	8	12	54
£110,000-£119,999	14	5	0	0	19
£120,000-£129,999	17	7	0	0	24
£130,000+	9	2	0	0	11
All	146	52	117	117	432

In 2003, the salaries of PCT chief executives were located within five salary bands, compared with nine bands for trust chief executives. In NHS trusts, 44.4% of chief executives supplying salary data in this survey in 2003 earned in excess of £100,000 (88 of a total 198 chief executives). Of these chief executives earning in excess of £100,000, 76.1% (n=67) were male, and 23.9% (n=21) were female.

Based on analysis of this sample population, in 2003, a PCT chief executive was more likely to earn a lower salary (under £80,000). Of PCT chief executives providing salary data in 2003 (n=232), 15.5% earned less than £80,000 (n=36). Of NHS trust chief executives supplying salary data (n=198), 9.6% earned less than £80,000 (n=19). In the case of PCTs, 21 women and 15 men earned less than £80,000.

In 2003, males were paid a higher average salary than females in both NHS trusts (£3,200 more) and PCTs (£400 more) but it was not a significant difference (p=0.2839 and p=0.7669 respectively). When adjusting for the size of the organisation for NHS trusts, females were paid more than males (£2,800) but it was still not significant (p=0.1100). For the PCTs, the results remained largely unchanged, the salary difference being £1,100 and the difference was not significant (p=0.2695).

In conclusion, in 2003, the salary range for NHS trust chief executives was wider than that for PCTs. A PCT chief executive was more likely to earn less than £80,000 than a counterpart in an NHS trust, and an NHS trust chief executive was more likely to earn over £100,000 than PCT chief executives. Within NHS trusts, three quarters of the high earning chief executives were men. In PCTs, more women than men earned a salary of less than £80,000.

In 2006, chief executives responding to the survey questionnaire provided data about their current salary as set out in table 5.10 overleaf.

Table 5.10: basic gross salary of NHS chief executives by type of organisation, November 2006

	NHST male	NHST female	FT male	FT female	PCT male	PCT female	All
£70,000- £79,999	1	1	0	0	0	0	2
£80,000- £89,999	0	0	0	0	0	0	0
£90,000- £99,999	1	2	0	0	0	3	6
£100,000- £109,999	17	3	1	1	3	10	35
£110,000- £119,999	11	16	3	1	11	17	59
£120,000- £129,999	10	9	9	2	12	9	51
£130,000- £139,999	17	5	5	0	7	5	39
£140,000- £149,999	11	2	3	1	3	2	22
£150,000+	19	1	5	1	2	0	28
All	87	39	26	6	38	46	242

In 2006, the salaries of PCT chief executives were located within seven salary bands, compared with nine bands for trust chief executives, although just two trust chief executives had a salary in a band outside the core seven bands of the PCT chief executives. One of these in the £70,000-£79,999 band was a learning disability trust chief executive and the other was from a small acute and community services combined trust. This consistency across chief executive type of overall salary range contrasts with the 2003 situation where PCT chief executive salaries were concentrated into a narrower and lower salary range than their trust counterparts.

In NHS and foundation trusts, just 3.1% of chief executives supplying salary data in 2006 less than £100,000 (5 of a total 159 chief executives). Similarly, of PCT chief executives, just two respondents (2.4%) earned less than £100,000 in 2006.

In respect of high earnings, an examination of salary bandings of £130,000 and above reveals that 70 NHS and foundation trust chief executives were in these categories, representing 43.5% of the NHS trust/foundation trust sample. Of PCT chief executives, 19 (22.4%) earned £130,000 or above, suggesting that whilst PCT chief executive salaries were no longer differentiated from those of trust chief executive colleagues in the lowest salary bandings, there continued to be a disparity within the highest bandings, with NHS trust/foundation trust chief executives being more likely to attract the highest salaries. An examination of the gender of chief executives earning £130,000 or above reveals that in NHS and foundation trusts, 60 of the 70 chief executives (85.7%) were male. Of PCT chief executives earning £130,000 or more, 12 were men and 7 were women. As with the data from 2006, assertions about gender and pay cannot be made without further analysis of organisational size.

In 2006, males were paid a higher average salary than females in both NHS trusts (£11,300 more, $p=0.0022$) and PCTs (£9,400 more, $p=0.0009$). However, when adjusting for the size of organisation, the difference decreased to £4,700 more and £6,400 more respectively, although the differences were still significant ($p=0.0352$ and $p=0.0010$ respectively).

Conclusion: in 2003, chief executives of NHS trusts had a wider salary range than their PCT colleagues, being more likely to earn at the higher levels. In 2006, although PCT chief executives' salaries were now concentrated in a range almost identical to that of trust chief executives, trust colleagues continued to be more likely to earn salaries at higher levels. Furthermore, in 2006, male chief

executives in both NHS trusts and PCTs earned higher average salaries than their female equivalents.

d) Ethnicity

The survey questionnaire asked respondents to describe their ethnic origin. The ethnicity profile of the chief executives responding to the survey in 2003 is set out in table 5.11 below:

Table 5.11: ethnicity of NHS trust, PCT and care trust chief executives in England in 2003

	NHS trust	PCT	Care trust	Total
White	204	239	3	446
Black Caribbean	0	1	0	1
Black African	0	0	0	0
Black Other	0	0	0	0
Chinese	0	0	0	0
Indian	0	0	0	0
Pakistani	0	0	0	0
Bangladeshi	0	0	0	0
Asian other	1	0	0	1
Other origins	0	1	0	1
Missing data	1	1	0	2
Total	206	242	3	451

Table 5.11 shows that 98.9% of NHS chief executives responding to this survey in 2003 were white, with just three chief executives reporting their ethnicity to be other than white. This suggests that in relation to ethnicity, the population of NHS chief executives in 2003 was overwhelmingly white.

The ethnicity profile of chief executives responding to the survey questionnaire in 2006 is set out in table 5.12 overleaf:

Table 5.12: ethnicity of NHS trust, NHS foundation trust, PCT and care trust chief executives in England in 2006

	NHS trust	NHS FT	PCT	Care trust	Total
White	128	32	83	4	247
Black Caribbean	0	0	0	0	0
Black African	0	0	0	0	0
Black Other	0	0	0	0	0
Chinese	0	0	0	0	0
Indian	0	0	0	0	0
Pakistani	0	0	0	0	0
Bangladeshi	0	0	0	0	0
Asian other	0	0	0	0	0
Other origins	1	0	1	0	2
Missing data	0	0	1	0	1
Total	129	32	85	4	250

Table 5.12 reveals that the ethnicity profile of NHS chief executives remained overwhelmingly white in November 2006, with 98.8% of respondents describing their ethnic origin as ‘white’.

Conclusion: there had been no change in the ethnicity profile of NHS chief executives over the period April 2003 – November 2006, with the population of chief executives remaining almost exclusively white.

e) Disability

Respondents to the questionnaire were asked whether or not they were registered as disabled. The results of this question for the 2003 survey are set out in table 5.13 below:

Table 5.13: disability status of NHS chief executives in England in 2003

	NHS trusts	PCTs	Total
Registered disabled	1 (0.5%)	3 (1.2%)	4 (0.9%)
Not registered disabled	204 (99.5%)	241 (98.8%)	445 (99.1%)
Totals	205 (100%)	244 (100%)	449 (100%)

Table 5.13 shows that four of the 449 chief executives responding to this question in 2003 were registered as disabled, namely 0.9% of the sample. Thus in 2003, 99.1% of the chief executives in this sample were not registered as disabled. This suggests that in relation to disability, the population of NHS chief executives was overwhelmingly not registered as disabled.

The results of the question relating to disability status for the 2006 survey are set out in table 5.14 below:

Table 5.14: disability status of NHS chief executives in England in 2006

	NHS trusts	NHS FT	PCTs	Total chief executives
Registered disabled	1 (0.7%)	0 (0%)	0 (0%)	1 (0.4%)
Consider oneself to be disabled	5 (3.7%)	0 (0%)	4 (4.3%)	9 (3.5%)
Not registered disabled	128 (95.5%)	32 (100%)	88 (95.7%)	248 (96.1%)

NB: respondents who answered 'yes' to the question 'do you consider yourself to be disabled' also ticked 'not registered disabled' in four cases and 'registered disabled' in one case.

Table 5.14 shows that just one of the 249 chief executives responding to this question in 2006 was registered as (and considered themselves to be) disabled, namely 0.4% of the sample. A further four chief executives identified that they considered themselves to be disabled (yet were not registered as disabled). This suggests that a total of nine chief executives considered themselves to be disabled, representing 2% of the overall sample. Thus in 2006, 98% of the chief executives in this sample did not consider themselves to be disabled. This suggests that in relation to disability, the population of NHS chief executives was overwhelmingly not registered as disabled, and a small number of chief executives considered themselves to be disabled.

Conclusion: the overwhelming majority of NHS chief executives do not consider themselves to be disabled.

f) Employment status

Chief executives were asked about their employment status, being requested to identify whether they worked full-time, part-time, or job share. The results of this question in 2003 are set out in table 5.15 below:

Table 5.15: employment status of NHS chief executives in England in 2003

	NHS trusts	PCTs	Total chief executives
Full-time	198 (100%)	235 (99.2%)	433 (99.5%)
Part-time	0 (0%)	2 (0.8%)	2 (0.5%)
Job share	0 (0%)	0 (0%)	0 (0%)
Total	198	237	435

Table 5.15 shows that 99.5% of NHS chief executives responding to this question in 2003 (433 of 435 respondents) were employed on a full-time basis. Two chief executives (two PCT) were employed on a part-time basis. This suggests that in 2003, the NHS chief executive population overwhelmingly worked on a full-time basis.

Table 5.16 overleaf sets out the results of the question about employment status for the 2006 survey:

Table 5.16: employment status of NHS chief executives in England in 2006

	NHS trusts	NHS FT	PCTs	Total chief executives
Full-time	129 (100%)	32 (100%)	84 (98.8%)	245 (99.6%)
Part-time	0 (0%)	0 (0%)	(1)* (0%)	(1)* (0%)
Job share	0 (0%)	0 (0%)	1 (1.2%)	1 (0.4%)
Total	129	32	85	246

* = chief executive of 2 PCTs, 1 full-time and the other part-time, counted in totals as a full-time employee

Table 5.16 shows that 99.6% of NHS chief executives responding to this question in 2006 (245 of 246 respondents) were employed on a full-time basis. One chief PCT executive was employed on a part-time basis. This suggests that in 2006, the NHS chief executive population was again found to work on an overwhelmingly full-time basis.

Conclusion: almost all NHS chief executives work on a full-time basis.

g) Length of time in post

Chief executives responding to the survey questionnaire were asked to indicate the date (month and year) on which they were appointed to their current chief executive post. This information was used to calculate the length of time that each respondent had been in their current post and these data for the 2003 survey are set out in table 5.17 overleaf:

Table 5.17: length of time in current post of NHS chief executives in England in April-May 2003

Time in post	NHS trust	PCT	Total
<1 year	15	6	21
1 year	49	104	153
2 years	37	101	138
3 years	32	24	56
4 years	18	0	18
5 years	10	0	10
6 years	8	0	8
7 years	2	0	2
8 years	5	0	5
9 years	4	0	4
10 years	8	0	8
11 years	5	0	5
12 years	4	0	4
Missing data	10	9	19
Total	206	245	451

Table 5.17 illustrates the difference between the two main NHS chief executive population groups in respect of length of time in post. In April/May 2003, NHS trust chief executives had been in post for between <1 year and twelve years, whereas PCT counterparts had been in post for up to three years. Of the NHS trust chief executives, 32.7% (n=64 of 196 responding to this question) had been in post for four years or more, whereas none of the PCT chief executives had been in post for longer than three years. This was clearly a consequence of the difference in longevity of the two forms of organisation, with the initial PCTs in England having been established in 2000.

It is also worth noting that even within the NHS trust chief executive cohort, in 2003, over two-thirds of respondents had only been in post for three years or less, suggesting a high rate of turnover in what are the main senior cadre of operational/accountable managers in the NHS.

Table 5.18 below sets out the time in post of NHS chief executives responding to the 2006 survey.

Table 5.18: length of time in current post of NHS chief executives in England in November-December 2006

	NHS trust	NHS FT	PCT	Total
Time in post				
<1 year	33	3	48	84
1 year	25	2	3	30
2 years	16	3	5	24
3 years	15	4	2	21
4 years	10	6	13	29
5 years	13	3	11	27
6 years	7	4	2	13
7 years	3	2	0	5
8 years	1	1	0	2
9 years	2	1	0	3
10 years	0	1	0	1
11 years	0	0	1	1
12 years	0	0	0	0
13 years	1	0	0	1
14 years	1	1	0	2
15 years	1	1	0	2
Missing data	1	0	4	5
Total	129	32	89	250

Table 5.18 illustrates the continuing difference, albeit slightly less marked (as PCTs had in 2006 been present in the NHS for six years, compared with just three years in 2003) between the two main NHS chief executive population groups in respect of length of time in post. In November/December 2006, the range of time over which NHS trust/NHS foundation trust chief executives had been in post was between <1 year and fifteen years, whereas some PCT counterparts had now been in post for up to six years. Of the NHS trust/NHS foundation trust chief executives, 36.9% (n=59 of 128 responding to this question) had been in post for four years or more (compared with 32.7% in 2003). Interestingly, 31.8% of PCT chief executives (n=27 of 85 responding to this question) had, in 2006, been in post for four years or more, suggesting that with the maturing of the PCT sector, some managers are proving able

to remain in post over the longer term. This is of particular note given the reorganisation of the PCT sector in 2006 that led to many mergers.

In 2006, almost two-thirds (63.1%) of NHS trust/NHS foundation trust respondents had only been in post for three years or less, suggesting a continuing high rate of turnover within this population. Of PCT chief executives, over two-thirds (68.2%) of those responding to this question had been in post for three years or less.

Conclusion: In both 2003 and 2006, NHS chief executives were found to have a high rate of turnover, with two-thirds having been in post for three years or less, however, there is a cohort of approximately one-third of trust and PCT chief executives who appear to be ‘long-lived’ in post.

h) Prior post and organisation

Respondents were asked to identify what their job title was immediately prior to taking up their current chief executive post, and to describe the type of organisation in which this prior post was based. The data collected in response to these questions in 2003 are summarised in tables 5.19 and 5.20.

Table 5.19: post prior to taking up current chief executive position, as described by NHS chief executives, shown by type of current employing organisation, 2003

Prior post	Current organ'n		Total
	NHS trust	PCT	
Chief executive	106	144	250
Director of operations	31	34	65
Director of finance	15	4	19
Deputy chief executive	11	8	19
General manager	11	3	14
Director of primary care	0	12	12
Chief officer	3	8	11
Director of nursing	6	2	8
Director or deputy director of social services	0	5	5
Director of mental health	3	1	4
Regional office head	0	2	2
Medical director	2	0	2
Chief ambulance officer	2	0	2
Freelance consultant	1	1	2
Other	2	5	7
Missing data	13	16	29
Total	206	245	451

Table 5.19 shows that by far the most common prior post for NHS chief executives in 2003 was to have come from a previous chief executive role (250 of 422 responding to this question, namely 59.2%). The next most commonly occurring prior post was director of operations (65 of 422, or 15.4%). NHS trusts were more likely than PCTs to have chief executives with a functional/professional background (finance director, director of nursing, medical director) and not surprisingly, PCTs were more likely than NHS trusts to have a chief executive with a background as director of primary care or within social services.

It should be noted that this data set needs to be analysed alongside data on prior organisation, for the role of a primary care group chief executive/officer was different in scope and responsibility from that of an NHS trust or health authority chief executive. Indeed, in 2003, 97 chief executives of PCTs (42.9%) had a prior post as a primary care group chief executive or chief officer.

An analysis of PCT chief executives' prior posts by prior organisation reveals that 25 (11.1%) were chief executives of NHS trusts, 97 (42.9%) were chief executives or officers of PCGs, 8 (3.5%) were chief executives of PCTs, 15 (6.6%) were chief executives of health authorities, one was chief executive of a local authority, one was chief executive of an ambulance service, one was chief executive of a health action zone, and one of a shared services organisation. A total of 65.9% of PCT chief executives were previously a chief executive, and if PCG chief executive roles are excluded, 23% PCT chief executives were previously chief executives of statutory organisations. By comparison, 52.8% NHS trust chief executives responding to this survey (n=102 of 193) had previously been chief executives of statutory NHS bodies (NHS trusts, PCTs, health authorities or strategic health authorities). This indicates that PCT chief executives were more than twice as likely as their NHS trust counterparts to be in their first substantive NHS chief executive post.

Table 5.20: organisation in which NHS chief executives worked prior to taking up current post, April 2003

Prior organisation	Current organisation		Total
	NHS trust	PCT	
NHS trust	154	43	197
Primary care group	0	102	102
Health authority or board	26	52	78
PCT	2	11	13
Regional office	2	6	8
Local authority	0	7	7
Dept of Health	1	6	7
Directly managed unit	4	0	4
Other	7	8	13
Missing data	10	10	22
Total	206	245	451

Table 5.20 sets out the organisation in which the chief executives were working immediately prior to the post they held at the time of responding to this survey. Of NHS trust chief executives, 78.6% (154 out of 196 responding to this question) came

to their chief executive post following a previous post in an NHS trust. A further 13.3% had worked in a health authority in their prior post. Thus 91.9% of NHS trust chief executives came to their post from an NHS trust or health authority.

For PCT chief executives responding to the 2003 survey, their profile of previous posts was markedly different, with 48.1% (113 of 235 responding to this question) coming to their PCT chief executive post from a primary care group or trust, and a further 22.1% coming from a health authority or health board (52 of 235). PCT chief executives coming from an NHS trust formed 18.3% of this sample. There were also seven PCT chief executives reporting a prior post in a local authority (compared with none such chief executives in NHS trusts) and six PCT chief executives who had had a prior post in the Department of Health (compared to one in an NHS trust).

What these data show very clearly is that in 2003, the chief executives of NHS trusts and PCTs had markedly different career routes, at least in relation to the post immediately prior to current chief executive post. NHS trust chief executives appeared to be largely drawn from NHS trusts (or from health authorities), whereas PCT chief executives were largely drawn from primary care organisations (primary care groups and trusts) and from health authorities, with a significant minority coming from local authorities, the Department of Health and regional offices.

In 2006, chief executives were again asked to report on the post and organisation in which they were employed immediately prior to moving to their current post. The data gathered in response to this question is summarised in tables 5.21 and 5.22.

Table 5.21: post prior to taking up current chief executive position, as described by NHS chief executives, shown by type of current employing organisation, 2006

Prior post	Current organ'n			Total
	NHS trust	NHS FT	PCT	
Chief executive	70	14	58	142
Deputy chief executive	11	4	3	18
Director of operations	9	1	1	11
Director of finance	7	2	1	10
Director of strategy	3	1	2	6
Director of nursing	2	3	0	5
Chief officer	4	0	0	4
Project director	1	1	2	4
Medical director	3	1	0	4
General manager	1	1	1	3
Director of performance	1	0	2	3
Other	16	4	19	39
Missing data	1	0	0	1
Total	129	32	89	250

Table 5.21 shows that by far the most common prior post for NHS chief executives in 2006 was to have come from a previous chief executive role (142 of 249 responding to this question, namely 57.1%). This figure is consistent with the proportion reported in 2003, when 59.2% of chief executives had come from a prior chief executive post. The next most commonly occurring prior post in 2006 was deputy chief executive (18 of 249, namely 7.2%). NHS trusts and foundation trusts were, as in 2003, more likely than PCTs to have chief executives with a functional/professional background (finance director, director of nursing, medical director) – 18 chief executives in trusts compared with one in a PCT. Interestingly, in 2006, the tendency reported in 2003 for PCTs to have a chief executive who had come from a prior post as a director of primary care, or as a director/deputy director of social services, appeared to be no longer present to any significant degree.

In 2003, it was deemed important to analyse these data on prior post alongside information about prior organisation, for the role of a primary care group chief

executive/officer was known to have been different in scope and responsibility from that of an NHS trust or health authority chief executive. Indeed, in 2003, 42.9% of chief executives of PCTs had a prior post as a primary care group chief executive or chief officer. Data on prior organisation as reported by chief executives in 2006 are set out in table 5.22 below.

Table 5.22: organisation in which NHS chief executives worked prior to taking up current post, November 2006

	<i>Current organisation</i>			
	NHS trust	NHS FT	PCT	Total
<i>Prior organisation</i>				
NHS trust	95	26	16	137
NHS foundation trust	2	1	1	4
Primary care group	0	0	7	7
Primary care trusts	15	1	44	60
Health authority or board	5	2	7	14
Strategic health authority	4	1	8	13
Other	4	0	2	6
Missing data	4	1	4	9
Total	129	32	89	250

In 2006, only seven of the 85 PCT chief executives (8.2%) responding to the survey reported their previous organisation to be a primary care group, whereas 44 (51.8%) had come from a PCT and 13 (15.3%) from an NHS or foundation trust. This points to a change in the population of PCT chief executives whereby in 2006 they were less ‘different’ from their NHS and foundation trust peers (in comparison with PCT chief executives in 2003), at least in being most likely to have come to their post from a chief executive post in the same sort of organisation in which they now worked.

An analysis of PCT chief executives’ prior posts by prior organisation in 2006 reveals that 8 (9.4%) were chief executives of NHS trusts or foundation trusts, 6 (7.1%) were chief executives or officers of PCGs, 34 (40%) were chief executives of PCTs, 6 (7.1%) were chief executives of health authorities or strategic health authorities, and 2

were chief executives of organisations that were not specified by respondents. Therefore, 54 (63.5%) of PCT chief executives were previously a chief executive, and if PCG chief executive roles are excluded, 56.5% PCT chief executives were previously chief executives of statutory organisations. This is a marked comparison to 2003, when just 23% of PCT chief executives had come from a previous post as chief executive of a statutory NHS body.

In 2006, 52.2% NHS trust and foundation trust chief executives responding to this survey (n=84 of 161) had previously been chief executives of statutory NHS bodies (NHS trusts, PCTs, health authorities or strategic health authorities). This indicates that in 2006, PCT chief executives were a little more likely to have previously been in a chief executive post of an NHS statutory body than their NHS trust counterparts (2003 68.2%, $p=0.0221$). This marks a significant shift from 2003 when PCT and NHS trust chief executives appeared to have had markedly different career routes, with PCT chief executives then being more likely to be in their first substantive chief executive post.

Conclusion: In 2003, PCT chief executives were more than twice as likely to have been in their first chief executive post, when compared with NHS trust chief executives. In 2006, this difference is no longer present, and in both cohorts, over half of the chief executives have had a previous post as a chief executive.

Discussion

The analysis of data from this survey paints a picture of the population of NHS chief executives in 2003 and 2006 that provides a backdrop to the detailed examination of the experience of women chief executives set out in this thesis.

Gender

The gender split in the overall chief executive population of the NHS in England in 2006 (63:37 male:female) was much the same as in 2003. In 2003, half of the chief executive population in PCTs were men, and half were women. This gender profile was more balanced than that for their NHS trust counterparts, which was roughly three quarters male, one quarter female. In 2006 however, the chief executive gender profiles remained much as in 2003, with the NHS and foundation trust population continuing to be over 70% male, and the PCT population being approximately half and half (54% female and 46% male), albeit with a slight increase in the proportion of women.

This raises a question as to why a greater proportion of women have been attracted and recruited to PCTs in comparison with NHS trusts. It may be due to the nature of the organisations (e.g. organisational factors such as being primary care and community-based, more networked than hierarchical, generally smaller in terms of staff headcount, being more focused on commissioning than provision), or to the responsibilities of the chief executive role in this context, or to a perception in the wider NHS that these posts are different and perhaps less ‘tough’ than their equivalents in NHS trusts. It is also of note that whereas women chief executives in NHS trusts were, in both 2003 and 2006, more likely to work in smaller organisations

than their male counterparts, this differential did not exist in this sample of PCTs, where if anything, women were slightly more strongly represented in the larger PCT budget categories. This raises a question as to whether this more balanced profile is due to the 'younger' nature of PCTs as entities, or whether women are somehow more comfortable working in PCTs, irrespective of organisational size.

Age

In 2003, most PCT chief executives were aged 40-54, but the overall profile of this group was younger than of their counterparts in NHS trusts. Three-quarters of PCT chief executives were under 50 years old in 2003, and only 4.2% were over 55. This younger profile might have been due to the newer nature of PCTs that had, in most cases, only existed since 2002. It could also have been due to a perception that PCT chief executive roles were somehow less 'senior' and challenging than those in NHS trusts, and hence the roles might have attracted younger, less experienced applicants.

It is worth bearing in mind here that 43% of PCT chief executives in this study who provided data in 2003 about their prior post came to their role from having been chief executive or chief officer of a primary care group (PCG). PCGs had a more restricted range of responsibilities than NHS trusts or PCTs, and were not statutory stand-alone bodies, but sub-committees of health authorities. A significant proportion of the population of PCT chief executives in 2003 were therefore in their first chief executive post of a statutory organisation, and had probably gone through a step change in relation to role and responsibility when they assumed a PCT chief executive role in 2002.

However in 2006, there was no longer any significant age difference between the PCT and NHS trust chief executive populations in lower age bands, with 81.8% trust chief executives and 92.5% PCT chief executives being in the age band 40-54. There was nonetheless a greater concentration of trust chief executives in the 55 and over category, suggesting that, unsurprisingly given the longer history of NHS trusts, it is still more likely that older chief executives are to be found in those organisations that have been established for a greater period of time.

In 2003, women PCT chief executives were more likely than their male colleagues to be young. This raised a question as to whether the setting up of PCTs offered women a chance to work in a chief executive post when they would not otherwise have been able to, or whether there was something intrinsic about the nature of PCTs that had attracted women (and younger women in particular) to work in them. There was also some hint in the data that women had a tendency to earn less than men, although these data need further testing in relation to size of organisation.

In 2006, the gender difference in relation to age of chief executives was no longer present in the data for age bandings up to 49 years of age. There were however a greater percentage of men than women in the higher age brackets. This trend towards an ageing of the female chief executive population could have two possible explanations: firstly that in the 2006 PCT reorganisation and merger process, younger chief executives might have lost their jobs more frequently than older counterparts, and secondly, that the NHS was witnessing an inevitable overall maturing (ageing) of those chief executives that had remained in post in PCTs.

In conclusion, in 2003, chief executives of NHS trusts tended to be older than those of PCTs, and male chief executives tended to be older than their female counterparts. By 2006, however, there was no longer any significant age difference between the PCT and NHS trust chief executive populations, or between genders. There were overall fewer younger chief executives, and the majority were aged 40-54.

Ethnicity

This research revealed that there had been no change in the ethnicity profile of NHS chief executives over the period April 2003 – November 2006, with the population of chief executives remaining almost exclusively white. Whereas there has been a shift in the gender balance of chief executives over the past 25 years, there appears to have been very little change in the ethnicity profile of the chief executive population. The Creative Career Paths Study of 1993 (IHSM Consultants, 1994) reported that 1% of top manager respondents were non-white, which is the same situation as in this study over a decade later in 2003 and 2006.

A Department of Health study of senior executives carried out in 1992-93 and reported in 1995 (Dawson et al, 1995) did not ask respondents about their ethnic origin, which in itself gives a message as to the lack of concern about ethnicity within the NHS until recent years. Given that PCTs are organisations set up to reflect and respond to the needs and characteristics of their local population, the ethnicity profile of PCT chief executives, whilst being appropriate in relation to gender balance, would appear to be far from ideal in relation to ethnicity. Similarly, in view of NHS policy about race equality (Department of Health, 2005b) the ethnicity profile of NHS trust

and foundation trust chief executives is clearly not yet in line with that of the general population, nor as set out in policy aspirations for NHS leadership and management.

Disability

There are hardly any PCT (or NHS trust) chief executives who are registered as, or consider themselves to be, disabled. In the 1994 Career Paths Study, IHSM Consultants reported that 1% of respondents to their 1993 survey of top managers reported that they were registered disabled. This report also noted that national data on disability did not exist for the NHS in 1993-4, and hence it was difficult to make assessments of how the top manager findings compared with the NHS more generally. The striking conclusion in relation to the 2003 and 2006 surveys reported here is that the percentage of top managers/chief executives reporting that they are registered disabled has barely changed over a period of more than ten years. It should be noted that when asked in 2006 about whether or not they considered themselves to be disabled (as opposed to whether they were registered disabled), 2% of the chief executive sample replied positively. This slightly higher percentage is likely to be on account of high earners such as chief executives not needing to register as disabled in order to have access to state financial support, and as this question was new in 2006, it is not possible to determine if the shift from 1-2% is an increase in the employment of chief executives with a disability, or merely a reflection of the change to the question in respect of registration as a disabled person.

What can be concluded from the survey questionnaire of chief executives in respect of gender, ethnicity and disability is that significant progress has been made over the period 1994-2006 in terms of the proportion of women assuming chief executive

positions, although this overall progress is enabled largely by the fact that more women have taken up PCT chief executive posts, and not by such a significant change in NHS trusts. However, in relation to ethnicity and disability, there has been no apparent progress over the same time period regarding the proportion of non-white or disabled people being appointed to chief executive posts in NHS trusts and PCTs.

Employment status

Almost all NHS chief executives work full-time, which is not surprising, given the nature of senior management posts such as these. However, it does raise a question about work-life balance and the declared commitment by the NHS to family-friendly working practices, for those working at the top of NHS organisations are clearly not espousing the alternative flexible patterns of employment exhorted in NHS policy (Department of Health, 2000b).

The Creative Career Paths study of 1994 found that:

‘Top managers in the NHS have a reputation for working long hours. This has been substantiated by the findings of this survey....All top managers work long hours irrespective of their personal and domestic circumstances..... Women [...] spend much more time on child care than their male counterparts.’ (IHSM Consultants, 1994, p39).

Information about wider demands on chief executives’ time was not collected in the 2003 survey. In in-depth interviews with women chief executives in 2006 (reported in chapter 6), the issue of work-life balance was examined in some detail, and a sense of regret at long hours worked, and the impact of this on the lives of their children, was a theme in a number of women’s stories of life as a chief executive. Of the ten women interviewed in that element of this research, just one had worked on a part-

time basis for a number of years when her children were young, although that was prior to assuming a chief executive post.

Interestingly, a study of unit general managers in 1986-87 (Disken et al, 1987) reported that 10.6% UGMs were employed on a part-time basis. This group was reported to comprise mainly UGMs who also practised as hospital doctors, GPs, nurses, pharmacists or dentists, although one job share was reported in England, as was the case in this research in 2006 when one job share was cited. Thus it would appear that the part-time status of UGM posts in the 1980s was related to a desire to continue with a clinical career in parallel to senior management. The overwhelming tendency continues to be for NHS chief executive posts to be worked on a full-time basis.

Length of time in post

In 2003, this survey demonstrated a wider range for time spent in post by NHS trust chief executives (between <1 and 12 years), compared with that of PCT chief executives (<1 to 3 years). This reflected the much longer time that NHS trusts had been in place within the NHS (i.e. since 1991, as opposed to 2000 for the date of establishment of the first wave of PCTs). Nevertheless, it was interesting to note that over two-thirds of NHS trust chief executives in 2003 had been in post for three years or less, suggesting high levels of turnover in very senior management jobs in the NHS. In 2006, this difference between NHS trust and PCT chief executives persisted, albeit in a less marked manner, for some PCT chief executives now reported having been in post for up to six years. The tendency of NHS chief executives to change post frequently was also detected once again, with some two-thirds of trust and PCT chief

executives having been in post for three years or less. Given the 2006 PCT reorganisation, one might have expected a more marked difference between the PCT and trust populations in this regard. However, it may be that a greater proportion of chief executives from 'non-merging' PCTs responded to this survey, whilst those in merging PCTs were either not in post (and clearly unable to respond) or in the midst of change and perhaps less likely to respond to a research study.

The Creative Career Paths Study (IHSM Consultants, 1994) reported that for the 'top managers' in their study carried out in 1993, the average time in post was 3.3 years, and this study would appear to suggest that the rate of chief executive 'churn' remains much the same almost 15 years later. There is, however, a cohort of approximately one-third of trust and PCT chief executives who, in 2006, appear to be 'long-lived' in post.

Salary

The salary range for NHS trust chief executives was, in 2003, wider than that for PCT chief executives, and overall, PCT chief executives were more likely to earn lower salaries than their NHS trust counterparts. There were a number of possible explanations for this finding. Firstly, this might have been associated with the different roles and responsibilities of NHS trust and PCT chief executive posts. Secondly, it might have been related to a perception in the wider health system that NHS institutions were somehow more important or challenging to manage and hence required higher salaries. Thirdly, the gender profile of the two chief executive populations (i.e. greater percentage of men within NHS trusts compared with PCTs) might be considered a reason for the salary differential, given what is known about

gender-pay disparity (Equal Opportunities Commission, 2007). However, after adjusting for organisational size within organisation categories, there was no apparent gender difference in relation to pay in either NHS trusts or PCTs.

In 2006, although PCT chief executives' salaries were now concentrated in a range almost identical to that of trust chief executives, trust colleagues continued to be more likely to earn salaries at higher levels. This suggests an ongoing tendency in the part of the NHS to place a higher overall value on leadership posts in large hospital trusts, in comparison with the organisations that commission and plan services, PCTs. Furthermore, in 2006, men now earned more than women in both NHS trusts and PCTs, even after adjusting for organisational size. This suggests that gender-pay disparity may be an issue within the more recent NHS chief executive population.

Prior post

Over half of the NHS chief executives in this study were in a chief executive post immediately prior to taking up the post that they were in at the time of the 2003 survey. Although at first glance the proportion of chief executives who had been a chief executive before looked almost identical for NHS trusts and PCTs in 2003, more careful analysis of the data revealed that 97 PCT chief executives had previously been a chief officer or chief executive of a primary care group (PCG). Given the difference in scope and responsibilities of PCGs compared with NHS trusts, it was not considered appropriate for this research to treat PCG chief executive positions as equal to or directly comparable with their counterparts in NHS trusts. Indeed, when further analysis was carried out about prior posts, it was revealed that in 2003, whereas 52.8% of NHS trust chief executives had previously been a chief executive of

a statutory NHS body, only 23.0% PCT chief executives had held such a prior role. Thus it was inferred that in 2003, PCT chief executives were more than twice as likely to be in their first substantive NHS chief executive position, compared with their NHS trust counterparts.

The degree to which this career history, with all the associated assumptions and mythology associated with PCGs and NHS trusts, had an impact on the early perceptions of PCT chief executives, and on the way that people have shaped that role, is difficult to assess. In the in-depth interviews with women chief executives carried out for this research in 2006-2007, some respondents talked about the perceived and actual differences between PCT and NHS trust chief executive roles, an issue that is explored further in chapter 6 (hearing the stories of the women chief executives).

It should be noted however that in 2006, only 8.2% of PCT chief executives reported having come to their post from a job as a PCG chief officer. Indeed, 56.5% of PCT chief executives had come to their post from a role as a chief executive of a statutory organisation, compared with 52.2% of trust chief executives. Thus there was no longer a difference in the immediate prior career paths of PCT and trust chief executives, this marking a sharp contrast with the situation in 2003.

Related to the above point is a question as to the nature of career paths followed by NHS trust and PCT chief executives. The data in this survey in 2003 suggested different paths for the two cohorts (with the exception perhaps of those who had moved from health authorities to trust or PCT chief executive posts, and those who

worked in NHS trusts before). By 2006, however, it was harder to discern such a difference in the data, suggesting that as PCTs evolved and matured, and became larger as a result of mergers, there may be some ‘coming together’ of the two main chief executive populations in terms of their career profile, at least in terms of the seniority and experience of the postholders.

Chapter summary

The postal questionnaire surveys carried out in 2003 and 2006 revealed that whereas chief executives of NHS trusts are male in almost three-quarters of cases, primary care trust chief executive posts are held by an almost equal number of men and women. PCT chief executives continue to be slightly younger overall than their trust counterparts, but this difference appears to be lessening over time. In respect of ethnicity, disability and employment status, it continues to be overwhelmingly the case that an NHS chief executive is white, able-bodied and works full-time and there is no sign of significant change in these areas. Turnover of NHS chief executives appears to be high across sectors, with over two thirds of postholders being less than three years in their current role. Whereas in 2003, PCT chief executives seemed to represent a less experienced cohort of senior managers who were most likely to have come into post from a role leading a primary care group, by 2006, there seemed to be some ‘coming together’ of the career experiences of the two chief executive cohorts. This suggests that as PCTs have become merged into larger NHS bodies, the people appointed to lead them are more similar to those in chief executive posts in NHS trusts.

The survey results in 2003 pointed to specific issues for women chief executives, namely a tendency to be more likely to work in a PCT, to be younger, and to be in a first substantive chief executive post. In 2006, women continued to be more likely to be working as a PCT chief executive, with no signs of any increase in the proportion of women leading NHS and foundation trusts. The apparent move towards a more homogenous chief executive population in respect of age, prior post and salary range does not seem to have translated into a significant change in terms of the types of roles being taken up by women. In chapter 6, the experiences of women chief executives of NHS trusts and PCTs are set out and examined in depth, by means of analysis of the narrative accounts given by ten women chief executives.

CHAPTER 6

HEARING THE STORIES TOLD BY THE WOMEN CHIEF EXECUTIVES

Introduction

This chapter sets out a narrative analysis of the ‘core stories’ distilled from the accounts given by ten women NHS chief executives, an example of a ‘core story’ being set out in Appendix 7. The narrative analysis has been carried within a pluralistic theoretical framework that considers the accounts to reveal a number of dilemmas faced by the women as they sought to present a story of ‘crafted multiple selves’ (Kondo, 1990). The analysis represents an attempt to try and determine what Holstein and Gubrium (2000) refer to as the ‘hows and whats of storytelling’, using a primarily dialogical approach to the exploration of paradoxes or dilemmas within the stories to tease out some of the different strands that form part of the construction of identity that is taking place within the telling of these stories of career and self.

Six dilemmas were identified during the process of narrative analysis, a process that first of all entailed an examination of each story as an individual account, a summary of which is set out in this chapter. A second, and more extensive, process of narrative analysis was focused on exploring the ten stories as a ‘community of stories’ (Holstein and Gubrium, 2000, after Chase, 1995), from which the six dilemmas were identified and then explored. The six dilemmas are as follows:

1. To where or whom should I ascribe my success?

2. How far should I acknowledge the support of male sponsors?
3. How can I reconcile my role as a mother with that of being a chief executive?
4. What have my career choices meant for my partner's role and career?
5. How can I reconcile personal and organisational values?
6. Have I adapted to the predominant male archetype of leader by becoming 'male'?

In drawing out these dilemmas from within the core stories, the conceptual framework used is that which was deduced within the literature review set out in chapter 3, and further considered in chapter 4 within the framework of Mabey and Finch-Lees' (2008) discourses of leadership and management research. This suggested that the overall approach was in the dialogical tradition of social constructionism, supplemented by insights from the critical and constructivist discourses (see chapter 4 for more detail).

The assumption is that these stories reveal, through the use of language by the women within dialogue created in an in-depth interview, what Kondo described as 'multiply crafted selves' – these selves being co-constructed by the women and the researcher. Within the analysis of the stories, it was assumed that there was a series of what Ford (2006) called 'contradictory discourses' of career and self, and there was an attempt to identify how the women sought to overcome the insecurity associated with a project

of self-management, drawing on Collinson's (2003) assessment of strategies of conformism, dramaturgy and resistance.

The chapter concludes with a brief discussion of what these six dilemmas reveal about the women's presentation of career and self, and sets the scene for chapter 7 which discusses the themes emerging from the narrative analysis of the ten stories together with the messages from the survey questionnaire.

Identifying the dilemmas in these stories of self

As explored in chapters 3 (literature review) and 4 (methodology), the reason for wanting to try and distil the dilemmas within the stories was a belief that these women were doing what Holstein and Gubrium call 'narrating the self'. These authors assert that 'over and over, we are relearning that selves are constructed through storytelling' (Holstein and Gubrium, 2000, p103). Thus in the analysis of the women's narratives, the intention was to concentrate on exploring the 'hows and the whats' of the stories told to the researcher, examining not only what was said and the themes that were revealed, but also *how* the stories were crafted, and in particular the paradoxical nature of the presentation of self, as expressed in what emerged as a number of dilemmas that appeared common across many or all the stories.

Dilemma 1: To where or whom should I ascribe my success?

The stories told by the women chief executives reveal a strong tendency to ascribe their professional success to luck or happenstance, even when, as part of their story, acknowledging their personal effort and competence.

For three of the women, their overall story was set out as a planned and deliberate series of logical decisions, of a desire to broaden experience, and take on new challenges. For other seven, the story was reported as being more concerned with events and opportunities that were due to luck. For the three reporting a ‘deliberate’ career path, their story was told in a way that suggested a conscious decision to proceed on a journey towards the achievement of a chief executive or similarly senior post. For example, chief executive B tells of an experience when a young ward sister:

‘I got bored and saw a man in a suit coming round my unit with the mayor one Christmas. He was the unit general manager and I asked him what he did and asked if I could go and see him and talk about my career. I went to see him and he asked me if I had thought about management. I saw that he had an Armani suit and realised that people up there were stopping me do what I wanted to do on my own unit, and decided that if I was going to make a difference I needed to be one of them up there.’

In a similar vein, chief executive E describes how she became very clear about her desire to be a chief executive and to move away from medical roles:

‘I then got a secondment to the Department of Health [...] I wanted to become an NHS chief executive and took advice from people in the Department of Health. They said go and get three years of trust and board director experience and then apply for a chief executive post.’

Likewise, chief executive A recounts:

‘I remember as a student nurse, in final block, scribbling down what I wanted to do. My plan was to be a matron by the age of 33, and I then wondered what I would do after that, be a matron for another 30 years? Of course the world and roles changed, but I guess I always had an expectation, even if not fully formed, that I would work my way up the career that I had chosen and that I expected to be at the top. As it turned out, I did get to be a director of nursing by 31 and UGM by 33 – I remember thinking that perhaps there was not anything more beyond that.’

It is interesting that the chief executives who explicitly talked about a desire to become a chief executive (or in the case of chief executive A, a matron) were from clinical backgrounds. This may represent a drive within them to move away from

their ‘shop-floor’ clinical role, to establish themselves in the management world, and achieve a specific goal. For the other women (none of whom was from a clinical background), it may be that having general management as their core and original profession made a goal of chief executive more implicit, a step to be reached on a journey whose stages seemed more well-defined.

For seven of the women (including chief executives A and B), their career path is described as being associated with ‘luck’, fortunate opportunities, or ‘being in the right place at the right time’. More specifically, some of the women chief executives described themselves to have been lucky in securing job opportunities, promotions, mentoring, and development support, albeit that a closer reading of their narratives reveals a story of career that contains a series of conscious and deliberate steps, made following reflection of personal and career development needs. For example, chief executive D, having described a career that has been based on a number of relatively long-term and stable periods in trusts and regional health authorities, and that enabled part-time working when her children were young, and also the achievement of a chief executive post in her 30s comments:

‘I have been extremely fortunate in my opportunities I have been given, probably because of the people I have worked with being enlightened about women having a contribution to make in the workforce.’

Chief executive D goes on to strengthen further this ascription of her success to luck:

‘I have been lucky – in my last coaching session I said I had been lucky and she said I should think about that and how far I had made those chances. I seem to perhaps avoid putting myself into positions where I might fail. I have been lucky in the chances given.’

It is interesting to note that although this chief executive reports the coaching advice to reflect on whether or not luck has enabled her success, and she surmises that

perhaps she has consciously chosen posts that will enable success (or not failing as she terms it), she then returns to the assertion of having been lucky, as though it is somehow not permitted to assert her own role in choosing and creating career success.

Chief executive B relates her career story in an upbeat, determined manner, identifying the active decisions she took in order to further her career, for example:

‘He was the unit general manager and I asked him what he did and asked if I could go and see him and talk about my career...’

‘...decided that if I was going to make a difference I needed to be one of them up there.’

‘I decided I needed acute experience and I moved over to a local hospital as manager for business development.’

‘I then branched out into management consultancy, which I combined with a part-time governance/performance director role in a local mental health trust....’

‘I really wanted this job and really went for it, although it had been promised to someone else.....’

However, when reflecting on influences on her career choices, chief executive B sums up a recipe for success as one where you have to compete and strive to be the best:

‘I believe you have to be reasonably bright to do the job, and instinctively to want to succeed, to be prepared to accept challenge and failure. I have always been competitive – I played hockey for [a UK region] so I am competitive by nature. I am always up for the next thing. You have to have an ego, and anyone who says not, that’s a load of crap. You have got to want to be the best and a leader, and to believe in your own capabilities – that is inbuilt, not something that is learnt.’

She then however draws luck and fortune into the equation, seemingly to explain why she has been able to succeed where others have not:

‘There are some good people out there who have those traits but are never afforded the opportunity. In my whole career, I have been so lucky to get opportunities (some were created by me) such as having good bosses who

would give me a go – that is partly a bit of luck. I have been afforded some damn good opportunities in being around people who wanted to develop others.’

Like chief executive D, chief executive B does acknowledge the some of the opportunities were of her own creating, but it is nevertheless interesting to note the shift back and forth between active decisions and choices, and the presence of luck and good fortune, within these narratives of career success. At the end of her account however, chief executive B asserts more strongly the planned and active nature of her career story:

‘You have to take opportunities. I have always planned what I am going to do, right back from when I met the UGM on the ward. When I became a chief exec, I thought I had won the Olympic gold medal and thought well, what the hell do I want to be? You then realise that you have to keep the medal gold, and you keep biting to see it’s real. I believe it is real now and that I am a competent chief exec.’

There is a lingering sense of luck and fortune, as expressed in ‘you keep biting it to see it’s real’, although she then asserts that she does believe in her success, and underlines her own competence.

Chief executive A explained, amidst an account that was very focused on decisive personal action and self-reliance, how she felt fortunate in the opportunities given to her throughout her career:

‘I have always been lucky in working with people who have given me a lot of scope, and recognised my capability and let me get on with things. I have worked with people who have enabled me to be promoted rapidly and had confidence in me, and let me develop roles beyond the usual scope of say personnel or nursing. The ultimate trust put in me was when I did the major reconfiguration planning, followed by implementation, where the regional boss realised I had got the guts to do it. [...] I have always been fortunate.’

Chief executive F similarly regarded herself to have been lucky in having people offer her support and opportunities, linking this to her non-traditional background as a

medical secretary, yet also asserting her own competence as a manager who is good to work with, and effective:

‘When you have not had a traditional education and route through the training scheme, people who give you time, support you, and give you project work are important. I have been lucky in that....I have been lucky to work with some good people who have seen my potential and invested in me – that has been a theme.’

Chief executive F, in talking about her luck, refers to the role of sponsors and mentors in the story of her career. As outlined in the next section, this is another dilemma that recurs within the stories of career set out by the ten women.

Dilemma 2: How far should I acknowledge the support of male sponsors?

A dilemma that was very clearly present within eight of the ten women’s stories was that of the role of sponsors within their narrative of career, and how far it was legitimate to acknowledge such individuals, and, as with luck and happenstance, ascribe some success to these other (mainly male and more senior) colleagues.

A ‘sponsor’ in this context is a senior manager who assumes an advocacy, patronage or otherwise supportive role on behalf of a career subordinate. The dilemma of whether or not to acknowledge male sponsorship typically involves a description of how, during the earlier stages in their career, the woman benefited from the support and advocacy of specific individuals, usually male senior managers. This support takes the form of: identifying the woman’s potential and encouraging training, career development, and applying for management posts; spotting the woman and then getting in touch to offer her a post; being a boss who challenged the woman and encouraged her to take on greater responsibilities; enabling the woman to combine work and family responsibilities in a way that was uncommon at the time; and taking

an ongoing interest in the woman's career over time, being available for advice and guidance.

The importance of these sponsors comes through in a number of the opening stories told by the women. For example, chief executive I reports:

‘I applied for a UGM post of a small unit – I was only 26. I was told after that the post had been stitched up for a local GP. However, Jim Green [a very well known senior NHS manager and chair] was on the panel as the external assessor, and he had given me my place on the national training scheme, and to everyone's surprise I got the post. [...] Then a reorganisation was looming and I started looking for other posts. I went for a UGM post in a large city, didn't get it, but the RGM had been on the panel and noticed me. He called me and said he had got a job that I would be ideal for. My salary doubled overnight and I was a regional director for the FPS reforms.’

Chief executive F, in recounting her career history of moving from a medical secretary post to ultimately be a chief executive, accredits a well-known NHS figure as having ‘spotted’ her at an early stage, and actually uses the term ‘sponsored’ to explain his role in her career:

‘My first post was in administration, working with Alan Edwards. Soon, I was encouraged to study further as I was deemed to be very able, so I did a BTec/HNC in public administration, and then became a senior PA at the local health authority.[...] Alan never lets me forget my humble origins – he is very proud of me, it is like he sponsored me and my career path. It has been circumstance and people pushing me, as opposed to ambition.’

Following their opening story, a question that was put to each of the women was ‘when you look back, who would you say has been particularly influential in your career development?’ This question led a number of the women to expand and reflect on the role of their sponsors, as demonstrated by chief executive H here:

‘John Brown influenced me in that he was intellectually very stimulating to work for and he got me looking at NHS management from a whole range of perspectives and I found that very inspiring and motivating. He used to push me, made me finish my masters degree, kept pushing me, gave me areas of

responsibility that were new and more challenging. He stretched me, and James Gordon was the same, making me do specialised commissioning to get me out of my comfort zone. John and James are far brighter than I am and I enjoyed the intellectual challenge they brought me – I thrive in that situation. They were also very supportive of my own personal development, and James was very supportive of me being in a senior NHS management job and having a young child. They were the key influences really.’

Chief executive G, in responding to the same question, commented:

‘My single most important piece of career advice to people is find a boss who can stretch you, challenge you, but who supports and rates you. And who is generous in allowing you to grow and develop. You should leave if you do not have that. For me, these bosses have been [names of five very senior male CEOs in the NHS]. I work best when I am really challenged and have to think about new issues. This is a group of men who have recognised something in me that meets their needs in their organisation and have let me rip in their organisation. They have taken risks with me.’

For chief executives H and G, these senior male managers are clearly significant figures within their narrative of career, representing either the reason for, or something distinctive and important about, a specific job or phase in their career. They admire and look up to these men, appreciate how they have been challenged by these bosses, and, in using language that is of both nurturing and protection (e.g. supportive, gave, rates you, recognised, grow and development) and also challenge and encouragement (e.g. inspiring, motivating, pushing, challenging, stretch, let me rip, taken risks), suggest a relationship that is almost that of a father who protects and encourages a developing child. In both of these examples, the women cite men who have been, or are, among the most senior and well-known health services managers in the UK, and this lends additional importance and resonance to the degree to which these men appear as key actors in the plot that is concerned with sponsors.

The sponsors identified by these women are not however exclusively men. Four women talked about female bosses or colleagues who had been significant in their career, these sponsors being a public health consultant, a senior NHS trust chief

executive, a strategic health authority chief executive, and the chair of the interviewee's trust. Chief executive J credits her female mentor with shaping her career, and talks in warm and energetic terms about her, and goes on to talk in slightly negative terms about the other key influential individual, a man:

‘My passion for health improvement comes from the DPH I worked with at the HA. She is fab and I love her dearly, one of the cleverest people I know, lovely and absolutely fab. Working for a forward thinking DPH absolutely shaped my commitment, as did working for the chief executive at my first hospital. From the chief exec of the large teaching hospital, I learnt how not to do things as well as what to do, especially about his very macho style in those days. He was charismatic and into the performance agenda, but there were things he wouldn't tackle.’

Chief executive F cites the former chair of her organisation, a woman, on several occasions during her interview, each time referring to her as a key source of support and encouragement, and suggesting regret at the chair's recent departure and replacement by a male chair who is described as ‘not being used to working with women...he is a bit old fashioned really’. This chief executive identifies the woman chair as being a reason for her having applied for her chief executive post in the first place:

‘I also applied for the [organisation] local to where I lived, but I went for this one further away because it was bigger and more complex, there was a supportive female chair [...] and we had created it, had the relationships. I felt that is I was going to be successful anywhere, I had more support and backing here than anywhere.’

When talking about the relationship between her family life and her career, chief executive F returns to the topic of her former chair:

‘I have had very good support here from the chairwoman, but she was left in October and we now have a different regime with a male chairman. She had faith and confidence in me, she wanted young, more dynamic, risk-taking people, and we appointed a team with a mix of experience and youth.’

As with the accounts of male sponsors, chief executive F describes her chair/sponsor as a risk-taker, someone who was prepared to believe in her, and who also provided support. Chief executive H, although talking mainly of significant male sponsors, does, when asked specifically about where she gets support from in her role as chief executive, mention a senior woman manager in the NHS who, along with two of the men she had mentioned as key figures in her career, she goes to ‘when I feel I need support or have a problem at work or whatever.’ In so doing, chief executive H is referring to mentorship, rather than sponsorship support, this being more concerned with career advice, rather than active enabling of new career opportunities, or so it seems. She goes on to reflect on the fact that she tends to turn to men for such support overall:

‘There are not many women who I go to for advice and support – that is quite interesting. There are not many women in senior NHS management who I respect. And women SHA chief executives are viewed by many as being the weaker ones of the cohort. It will be interesting to see what pans out with the females...’

Chief executive H, as we will see when exploring dilemmas related to personal values and motherhood, has strongly negative views about her mother, and very positive and affectionate attachment to her father as her key role model.

Two of the women chief executives did not mention any particular individual as being, or having been, in a sponsorship role in their career. These women, chief executive E and chief executive A, have in common a clinical background (one as a nurse and the other as a doctor) and also a family background that was clearly far removed from their current experience as chief executives. Chief executive E was the carer for her widowed mother who suffered from depression and latterly dementia, and chief executive A was from a large working class family. Both these women tell

a story of self-sufficiency, personal effort and ambition. Their stories are strongly heroic, reporting significant effort in the face of great odds, of battling through and gaining the prize of a chief executive post.

Chief executive A acknowledges in general terms that:

‘I have been lucky in working with people who have given me a lot of scope, and recognised my capability and let me get on with things. I have worked with people who have enabled me to be promoted rapidly and had confidence in me, and let me develop roles beyond the usual scope of say personnel or nursing’.

However, she concludes:

‘I don’t know what has influenced me, I am just who I am’ and when asked about sources of support notes: ‘It is all internal. I am just very focused and I don’t like talking about problems at work...I don’t have a lot of self-doubt and if I believe in what I am doing, I want to get on and do it. I do what I do because I think it is the right thing to do.’

Chief executive E asserts her self-sufficiency (albeit with support from her husband and male chair) thus:

‘I had no training or induction and didn’t need any because I had run my own business – I don’t need to work. [...] I would not have wanted Women’s Unit and all of that, for I would not have wanted special help. My experience of running the business is what has been most valuable. [...] My support comes mainly from my husband and family. And I have a very supportive chairman. I don’t have any mentors, because you are on your own.’

It is of interest to note the same echoes in chief executive E’s personal story of a sense of being on one’s own and having to cope whatever the odds:

‘I am influenced by the drive to always want to do better. I came from a working class family and no-one else went to university in my family. I was the carer for my mother from the age of 11. I worked before school each day in order to support my mother. I have no siblings – there was just me and mum.’

Chief executives A and E appear however to be the exception rather than the rule, for the other women's stories resonate with the names and persona of senior male managers from the NHS, people whose reputations were or are among the most renowned in UK health services management. These women who have reached some of the most senior leadership posts in the NHS appear to want to cite their male sponsors as key actors within the story of career and self. How far this is a desire to deflect the ascription of success away from themselves as individuals, a wish to impress the listener by association with key national figures, or a straightforward acknowledgement of support given, is impossible to surmise. What is clear is that the accounts of male sponsors resonate strongly within the overall community of stories, creating a sense of presence as patrons or father figures during the women's career adventures.

Dilemma 3: How can I reconcile my role as a mother with that of being a chief executive?

For the seven chief executives who had got children, a dilemma that resounded clearly through their narratives was that of trying to reconcile the role of mother of children with that of being a chief executive of an NHS organisation. All bar one of the chief executives who were parents expressed a degree of regret at not having had longer for maternity leave, not having worked part-time at all or for longer, and at not being home enough for their children as they were growing up.

Chief executive J was the chief executive who appeared to express the most regret at the impact her work had had and was having on her children. She talked in the interview to the issue of how her middle son viewed her working, for example:

‘I had a conversation with my boys a couple of years ago, I had missed something, I don’t remember what, and the second son said that he wished I wasn’t always working. I said well I could do that but this is how things would change. First son said oh I want you to keep working, but the second one said he would be happy not to have those things – I have had to address a few of those issues with him really. My husband doesn’t work every day of the week so he is around a lot which is good. My second son would happily live on the park bench if I was around all the time. So sometimes you feel bad about that. He had a rugby match yesterday and I could not get away so he had no-one to watch him. But you compensate for that by being there when you can.’

Chief executives J’s interview had started, when asked to tell her story, with a concise and very job-focused account, with almost no mention of the ‘rest of life’. However, the brief and somewhat perfunctory initial story of career became, following probing questions, a more complex and emotional tale of a woman in a senior leadership post struggling with some sadness at her lack of time to be mother to her children.

This chief executive’s story was initially portrayed as one of work and career progression, yet within and beyond that was a powerful discourse of family and motherhood. She summed up the dilemma about motherhood and a chief executive role as follows:

‘The NHS is an interesting beast and you never quite feel you are giving it enough. With children, you have their life as well as your own, and so you never feel as though you are doing anything well enough. You always wish you could stay a few more minutes, but can’t, and you never quite do everything to the degree that you want to.’

Chief executive C expressed regret at not having had longer maternity leave, and although her husband had been a full-time father for five years, wished that she had been, and was now, more available to her children:

‘In 1997, my second child was born. With both children, I worked until the day that they were born, regrettably. I look back now and think that I wish I had spent more time with them when they were babies. The elder one was not

quite four months old when I went back to work and the other one was just 6 weeks old. The elder one was only a week old when I went into work for a meeting about the future of the local health system, leaving her with a nurse outside. That is part of the attractiveness now about making a significant life change for you can do more with them when they are older and they more want you to do things with them and be there. In 2001 when we moved north, my husband gave up work. For various reasons, he has not been that desperate to work at his career. He does the school runs, assemblies and all of that. If I am held up here, I am not worrying about them. I do feel quite guilty about working, I have to say. I get text messages saying ‘what time are you coming home mummy?’

Chief executive C, like chief executive J, explains how she uses the high salary associated with her post as a reason to give to her children when they complain about her working long hours:

‘I forget to buy things for them some times, or promise something that they say I promised the previous weekend. I then tell them that they are only able to ask for all these material things because of my job...but I don’t like to hear myself saying these things.’

Chief executive G, whose husband also gave up work and cared for their children full-time, expressed some degree of regret about not having spent enough time with the children, now that they had left home for study and work:

‘I am a very proud mum and my family is incredibly important to me and I have been married for 28 years and we are a very strong unit. I feel so much gratitude to my husband for that he gave up, and hence I make a priority of tending that family unit so that it will remain strong. Years ago, all the women who were senior were unmarried and/or childless. I decided that is I was going to buck that trend, I was not going to take my family for granted. Children have left home and it is a source of sadness that I was not there for them as much as I could have been. But we made our decisions and they seem to have worked out.’

Chief executive F, who was about to have her second child at the time of her interview expressed regret at how much time work takes from her life: ‘We have cleaners and lots of extra help, and we use weekends to relax and catch up. But we don’t have any hobbies or social life. Work is still dominant, although I would like it not to be...’ Later in the interview she reflected on her young son and his attitude

towards her work, expressing some sadness and regret, yet also her desire not to be at home for more than a day of the working week:

‘My son is too young to understand what I do, although he knows I go to work and accepts that Dad is at home and Mum goes to work – he accepts this as his life and routine. Perhaps when he goes to school he will realise that mums are at the school gate and I am not. Maybe it is because we had children late and got used to work, or perhaps we have just done it differently. But I couldn’t cope with being home, perhaps one day a week, but not more really.’

This paradox of regret in relation to being an absent parent, together with a strong desire to work and create a self of career in parallel to the self of mother, comes through in a number of the women’s stories. A strong theme, often recounted with significant emotion, is that of not being able to ‘have it all’ and thus having to make compromises between career and family life. Chief executive D summed up her conclusion about having to make compromises when being both a mother and a chief executive as follows:

‘You have to decide in life, you can’t have it all, that’s a kind of a real bit in your brain that you can’t have it all and can’t expect to have it all and you are going to have to make compromises....to be with honest with you, later on, I compromised family time for work. And you can’t have it all, you can’t have a successful career as a woman, being a chief executive, and spend the time that you should be spending with them. You just can’t, it is just impossible, and I would defy you to find anybody who say they can, because it is not true. You have to live with it.’

Chief executive H presented a positive picture of her decision to have one (and not more) child, to adapt her working pattern, and to negotiate with her husband that he would lead on their child care responsibilities:

‘I have got more selfish really and I want to participate in my child’s upbringing and see [x] grow up. My husband does most of the childcare, but I don’t want to miss the carol concerts and so on and I never do. I try to have Fridays as working at home days and have 10 days a year unpaid leave on top of annual leave. I try and set an example about that sort of thing as a senior woman leader – and I think I am a better manager as a result since I became a

mother and spend less time at work. I can see the wood for the trees now and some space is created by doing something else.’

It should be noted that the one chief executive who was a mother and who did not express any feelings of guilt and regret (chief executive E) had spent a few years out of employed work when her children were small, and only became a chief executive when her children were at senior school, in contrast to the other mothers whose children were very young or even babies when they reached chief executive level. She did however emphasise the importance to her of knowing that she took time out from employed work when her third child was born, almost setting this out as a counterpoint to the regret she might have otherwise felt:

‘I had my three years off because I was absolutely determined to be a proper mum. It was the best thing I ever did, taking three years, and I was able to be what I wanted, a full-time proper mum. I knew I would never regret it. I did help with the family business, but I loved it. People said I would never get back in and it would be difficult, but you can do what you want, if you mould what you do’.

Dilemma 4: What have my career choices meant for my partner’s role and career?

As indicated above, a key recurring theme in the stories of the women in this research who are both chief executives and mothers is the extent to which they have developed a model of family life whereby the woman is the main or sole breadwinner, and the man (the partners of the chief executives with children were all men) is the primary child carer and home maker. Of the seven chief executives with children, six had got a husband who either worked part-time and took the lead with childcare, or stayed at home as a full-time parent. The one other chief executive who was a mother was chief executive E, who, as mentioned above, had reached chief executive level at a time when her children were becoming independent.

In this research, the existence of the man who stayed at home with the children was often revealed only after some prompting about family life and its relationship with the woman's career, creating a sense that these men were in some way hidden from view or 'silent'. In contrast to the vivid and present male career sponsors in most of the stories, these men appeared relatively absent from the women's story of career.

It was however evident that the men were giving invaluable support to the women and their families, cited as providing continuity and everyday care for the children, and as taking responsibility for the running of the home and family. Some of the women expressed their gratitude and admiration for their husbands in this regard, while others stated that this was part of the deal they had struck. Examples of how the women revealed and described the existence of their home-making and child-caring partners are set out below:

'When I went back to full-time NHS management after having the children they were 5 years, and 17 months. We had a nanny for the first 6 months I was working but I was really unhappy about someone seeing more of the baby than either of her parents. I talked to my husband about part-time work, but he said that I was on a steeper career trajectory than him and had more opportunities to progress. We were earning the same, and he suggested that he give up work. You could have knocked me down with a feather, for he is not exactly a new man, nor the archetypal househusband. We role-swapped and he was fantastic at bringing up the kids, he stayed at home until they were eight or nine, and at a huge cost to his career. Whole family ethos has been that mum's career is the bread-winning career and dad's main job is to see to the kids.' (chief executive G)

'In 2001 when we moved [...], my husband gave up work. For various reasons, he has not been that desperate to work at his career. He does the school runs, assemblies and all of that.' (chief executive C)

'The deal with my husband has always been that my career came first. He is not that ambitious, he loves his job, is more principled than I am and made a conscious decision to work in a school with disadvantaged kids. [...] Because he is a teacher he can look after [our child].' (chief executive H)

There was also a suggestion in this research that the issue of having a home-maker partner was not confined to childcare responsibilities. One chief executive (chief executive I), who talked of how she had actively chosen not to be a mother, described the support lent to her by her husband who had chosen to work in a home-based occupation:

‘My husband is incredibly supportive, does loads more around the house than I do, which is really great. I have a really good set-up now.’

One of the women, chief executive D, had worked part-time (three days a week) for seven years whilst her children were young, before the decision later in her career for her husband to become the main childcarer, and reflected on the experience as follows:

‘I always wanted to have children and I also wanted to work. I knew that I was not the sort of person to sit at home. My husband is extremely supportive and has always known that I need a demanding career. In the early days, it was about me going part-time and being home with the kids. When the kids were very little, I had personal rules that I always stuck to. I was always home between 5 and 8.30pm. I always collected them, and never did any work while they were awake. And I never did evening meetings, and never did anything at weekends – if there was an event at the weekends, the kids came too. I thought it was their family time, evenings and weekends, and kept that very separate.[...] However, chief exec jobs have got very demanding and my husband was working full-time too in a senior role as a finance director. As kids get to be older and teenagers, they need you when they need you, after school. A couple of years back, my husband decided to hand in his notice, go self-employed, and work from home.’

This chief executive describes a situation where she and her partner have ‘taken turns’ to lead in the care of their children, and it appears from the narrative she sets out that she regards this decision to work part-time for a number of years as having been critical to her role as a mother, albeit that she expresses some (but apparently less than the other women chief executives’) regret at her work’s impact on her family.

Chief executive F, who was pregnant at the time of her interview, described how she and her partner had reached a point where he felt it was her turn to adapt her working pattern to parenthood, and that he might return to closer to full-time working. As with chief executive D's experience, this suggested a process of negotiation and reshaping of childcare and working arrangements over time:

‘It suited my husband at the time [our child] was born, to work part-time and do the majority of the childcare, although I think he underestimated how hard work that would be. [...] He works 3 days a week and has enjoyed it, but feels he has done his stint, and feels he cannot go through this again with another child, and is thinking of going back and working 4 days a week.[...] the logistics of one at school and another baby are harder and it has provoked a discussion that suggests that I should take more responsibility.’

Chief executive A, the only chief executive interviewed who was both single and without children reflected on the issue of chief executives, their partners and childcare choices as follows:

‘Marrying and having children has just never really been in my psyche so I have had the freedom to do this job. That is my choice and I am perfectly happy being single for I have loads of friends and loads of interests and it suits my lifestyle very, very well. It is back to whether or not people are where they are because of the choices they have made rather than because of gender. You could argue that family may be an influence more if you are female, but I just don't know. I have a friend who is a chief executive [...] and her husband gave up work about ten years ago to look after the children and that has worked really well for them, in an environment where men are butch. So there is a traditional model and then people make choices, and issue is about what support they get to do it. My friend and I are both successful chief executives, she has a family as well and I haven't bothered with that, but it seems to work for both of us. It is about having something outside of work that gives balance and keeps you sane. These male partners are under the radar, staying at home and enabling women to be the breadwinner. It is interesting.’

What is clear from this research is that six of the senior women had, together with their partners, elected to address the challenges of time pressures and childcare options faced by dual-career families by shifting to a situation where only one partner

(the woman) worked, or where the man assumed part-time or otherwise lower key employment. This was reported by the women to be beneficial to their children, to the working life of the senior woman leader, and to make life for the whole family or partnership of a better quality and more manageable pace.

Dilemma 5: How can I reconcile personal and organisational values?

The women's accounts revealed a strong sense of dissonance between their personal beliefs and values related to public service, and what they perceived was a move by policy makers and senior managers towards a health service more concerned with competition, productivity, and values more commonly associated with private sector management. The interviews took place against a backdrop of sudden and severe financial restraint in the NHS, at a time when the service was considered to be overspent and in need of 'bringing back into line', this entailing redundancies and service cuts in some areas of the UK.

Chief executive C summed up her discomfort with the situation in respect of NHS policy direction as follows:

‘A lot of us are trying to reconcile where the NHS is going at present. It has been a tough year, and I spend three hours a day travelling in a car. This leads you to question if you want to keep on doing this for the next five years.’

Later in her interview she returned to the theme of the clash of personal and organisational values:

‘The other thing at the moment is that I am not exactly dissatisfied, but the NHS as it is now is not the NHS I joined 30 years ago. It is not that it didn't need changing, for it did, but I have a little nagging doubt about how far they are willing to go to get the outcome they are after.’

Chief executive B similarly restated her belief in the core values of the NHS and her frustration with what she saw as the government's current policy approach:

'I believe in the welfare state and having a safe system that people can access regardless of wealth or vulnerability. There is emergency care, elective care, chronic disease management and long-term care. Government is obsessed with elective care because it gets votes. But they have to start planning emergency and long-term care – they have gone absolutely OTT on elective care. I don't mind patient choice, but [...] there are things that work and things that don't. This government has lost the plot.'

It is striking that the women felt able to be forthright in their criticism of government policy in the protected and confidential setting of the research interview. Three of them went on to explain how hard they found it to have to 'act a part' and be supportive of prevailing health policy, especially when communicating with their staff, and yet dealing with what they considered to be bullying behaviour from 'on high'. Chief executive J explained it thus:

'As chief exec, you get grief from below as you take even more money out of their service, and you end up doing a good line in Billy No-Mates at the moment – that is tough. The personal stuff that goes on, it's bullying really. We have been told that we can't talk to the media at the moment and are being told as chief execs in this patch that our personal futures depend on us behaving in a particular way. There is clearly a case for corporate behaviour but there is also a case for public accountability. [...] I don't like not sleeping at night because of infection control rates, high bed occupancy rates, management issues and the latest phone call from the strategic health authority telling me the mortgage is at risk yet again. Those kind of things are difficult. I like to be able to explain things to staff, and the public, local people, in ways that are understandable and I can't at the moment.'

Chief executive H echoed these comments about NHS management culture and the treatment of senior NHS managers:

'I also find some of the bullying culture frustrating, people threatened with the sack and 'you will do it all costs' approach. I am fully able to take responsibility and be accountable, but it's not right to scapegoat people, especially for historical problems. I am only working with one person I was working with a year ago – most of them are not in the NHS now for they have

been made redundant. It has been quite brutal in its consequences for senior managers.’

This theme of feeling subject to bullying behaviour from the strategic health authority and Department of Health recurred in number of the narratives. Chief executive I was particularly vehement in her critique:

‘Intellectual incoherence, an over-weaning, over-weaning arrogant sense from the centre at the moment. There’s nothing they can’t bruise about a bit, quickly moving on before it has been properly evaluated, to select the next victim. Pell-mell, ill-thought through, ill joined up, incoherent, poorly evidence-based measures and propositions which we are subsequently beaten up for not achieving. That’s very frustrating. It is a very de-motivating environment in this region at present due to the financial situation and there is a lot of bullying going on. You get people on the phone shouting at you if you have put the wrong number on your financial returns.’

This chief executive went on to describe the importance of protecting oneself as a chief executive, developing means of emotional resilience and self-esteem in the face of sustained pressure from senior managers:

‘If you didn’t [protect yourself], you would just assume that you were a complete shower of shite, for that is everyone’s view from the health secretary down, that the managers are rubbish and got us to where we are, can’t calculate the money, and so on. The primary requisite to being an NHS chief exec at the moment is emotional resilience, not your intellectual capabilities or know-how – they are all further down the list than emotional resilience and strength.’

She returned to this theme of emotional resilience when explaining how she conceptualised the role of the chief executive:

‘Three years ago, I would have said it was all about vision and clarity of direction, but actually it doesn’t matter if that is completely correct. What matters is to be emotionally resilient, to model behaviour, be consistent and act as integrity with those you lead. That will become the touchstone of the organisation. In times of famine and storm, it is about lashing yourself to the bloody wheel and trying to stop it moving too many degrees off course. No sunshine and no horizon, so you can keep your vision to yourself. It is about plotting the course and staying steady. [...]. Authenticity is part of effective leadership, and I try to be authentic and to be myself. Frankly at the moment, it is more about dissembling. That is not particularly uncomfortable, for

everyone works for me, and they look to me as the boss and performance manager, and there is a distance that cannot be transgressed. But it is very dangerous to pretend. But if your feelings are betrayed and you appear to be panicked or despairing, you cannot lead. So part of the job is about best face forward. At the SHA however, that is part of the role – however much they push and prod you, you never ever show you are the slightest bit afraid and I don't feel any guilt about that, acting, and saying everything is fine and we are enjoying all the challenges.'

The women's accounts reveal the perceived toughness of the policy context and management culture, and the need for chief executives to find a way of trying to be true to their personal values and act with integrity, yet still be able to survive and enable their organisation a degree of protection from the strategic health authority and Department of Health.

Chief executive I identified the importance of acting out a part as a form of resistance to pressure from above - she clearly found this uncomfortable, but acknowledged that 'if your feelings are betrayed and you appear to be panicked or despairing, you cannot lead. So part of the job is about best face forward'.

This story of resistance by the women in the face of the wider NHS culture and policy came through more strongly in some stories than in others. For four of them, it was presented as an account of refusing to accept discriminatory behaviour, and in persisting in securing the job to which they felt they were entitled, or bringing to light unacceptable bullying or harassment in the workplace. For another four (including one of those who told a story of resisting discrimination), it was recounted more as a story of forming alliances with other women to develop alternative approaches to management, and to create networks and partnerships 'under the radar' of the prevailing management culture. At times, resistance appeared to be associated with creating a situation where the woman could get on and manage her organisation in the

way that she preferred, actively resisting or managing the perceptions and culture of managers and policy makers at higher levels in the NHS.

The refusal to accept discriminatory or bullying behaviour was probably strongest within the story told by chief executive I. This chief executive, from the start of her story, frequently asserted her preference for being different, challenging and a fighter, and appeared to relish this stance:

‘I am not particularly typical in that I have chosen to work in different and sometimes unfashionable areas.’

‘Give me an injustice and I will get my armour on.’

‘Perversely, I prefer to stand up against what I am told to do, and to focus on doing what is right for this population.’

‘I stand my ground if they phone me – I say what I can do, but I will not lie, and I tell them I will not be spoken to in that way and my integrity comes first.’

Along with this chief executive, two others, (chief executives G and B), persisted in applying for chief executive posts even in the face of serial rejections, or tip-offs that posts had been ‘reserved’ for male candidates:

‘I heard afterwards that it took the panel a long time to be persuaded that I as the appropriate person for the job.’ (chief executive G)

‘I applied for a UGM post of a small unit – I was only 26. I was told after that the post had been stitched up for a local GP.’ (chief executive I)

‘The rest of the [...] team, the men, really didn’t want me there and were very jealous of the fact I reported directly to the [boss]. They changed my job description between offer and job start so that I was not a member of the executive team. [...] I only stayed 10 months [...] for I got so hacked off [...] I had a blazing row with [the person who thought I should report to him] one day about stealing my work and putting his name on my work, and I wasn’t having that.’ (chief executive I)

‘A major teaching hospital chief exec post then [in 2000] came up locally and I chatted with the regional director about this. He said that I could apply but

would not be appointed, for the doctors there would never wear a woman chief executive, however good I was. He made it clear that for this part of the world, a woman teaching hospital chief executive would just not be acceptable.’ (chief executive G)

‘I knew that the [...] job had been promised to a man. So I decided to apply for this, with the support of my friend at the trust where I had been working, as an attempt to break up the old boys’ network. I really wanted this job and really went for it, although it had been promised to someone else. [...] The clinicians voted unanimously for me. The following day, I had a formal interview, and the SHA chief executive wanted to appoint the man he had promised the job to. The chair said no, he wanted me. For two days, I heard nothing and this really hacked me off. It took the chair two days to persuade the SHA chief executive and the board that I could be appointed. I heard later that the SHA chief executive had called up all the chairs I had ever worked for, to get a feel for me – this was disgraceful really.’ (chief executive B)

As noted earlier, four of the women talked about one of their strategies of resistance to the prevailing organisational culture being one of developing alliances with other women. Chief executive B described how the arrival of another woman chief executive in the local health community had presented an opportunity to:

‘[pull] together a managed health network for the county, to try and demonstrate to the government that you can be both clinically viable and financially stable. We can try this out between us, for we have worked together before – we will try and deliver on the government’s agenda through a collaborative approach. [...] This is a collaborative and networked approach. We reckon that between us, if the women cannot do it, well the men never did! I was the first woman chief exec in this area – now we have two female chief execs, a female chair in the PCT, and we are giving it a go’.

For chief executive C, the alliance formed with women colleagues was crucial to her support and survival strategy as a chief executive and took the form of:

‘what I call the coven, as in witches. A group of half a dozen of us who have dinner together every six or eight weeks. They are people I have worked with, all women, and I put it in the diary as “the coven” for we can really get quite witch-y and sit there casting spells. [...] There is quite a strong bond between us and we do get quite bitchy.’

Chief executive G talked about how she used her role as chair of the acute trust chief executives' network in her region as an opportunity to try and 'seek a consensus beyond a "might is right" approach'.

Chief executive J developed this concept of working in a more consensual approach, when describing how she was trying to manage her organisation:

'I have been trying to get people to take more responsibility and deal with their own problems' and goes on later to comment that 'women are better at building things, men at knocking them down or working with what is there'.

Chief executive D echoed this theme of building when she commented:

'That is what I like about being a chief exec...it is about freedom, being able to do things, I can shape things as a chief exec, it is my sandpit and I can make it what it is. I am my own boss, shaping things – it is not other people shaping it for you.'

Interestingly, for this chief executive, this was not so much a claim about resistance or subversion, but of her role as one of builder and shaper, of being someone who felt she had sufficient space to create local values and context for bringing about change.

This suggests that the extent to which the chief executives were feeling a need to resist national policy and NHS culture differed, just as did the strategies adopted in order to address any perceived need for resistance.

For some of the women, their approach to resisting the prevailing culture and policy context was based on being prepared to act out a certain role in order to create a desired sense of competence, confidence or compliance. For example, chief executive I elected to present a calm and controlled exterior to the strategic health authority in order to resist their attempts at bullying her about financial and other targets.

Similarly, chief executive G talked about having to:

‘create credibility from a position where all I had was my personality – it is quite scary really and more so as I get older and realise how fragile that is’.

She also talked in this part of the interview of her work supporting black and female managers in the NHS, creating a sense of someone who not only worked to create a particular sense of herself as an actor on the NHS stage, but also of a person who regarded herself as a fighter on behalf of others. This theme of equality was one that was referred to by several of the women when asserting how they were trying to resist the prevailing management culture. Chief executive H described a desire to set an example that challenged the prevailing culture:

‘I know you can set an example as a chief executive, but... I was recently asked by the local acute chief executive to come to a meet at 7.30am and I refused, for I just will not go to a meeting at that time of the day. There is that culture, partly around how consultants work, but I am just not prepared to do that now.’

Chief executive B took this a stage further and asserted:

‘The chief exec has to really believe in what you are doing, for if you don’t as the chief exec, why the hell should anyone else? People need to respect and follow you’.

What was clear was that despite a significant degree of unhappiness with the culture and policy context within which they were working, these women had chosen to adopt a range of strategies in order to gain the personal or organisational support they needed in order to be able to manage their organisation in a way that accorded with their personal values about patients, communities, staff, or the NHS as a whole.

Dilemma 6: Have I adapted to the predominant male archetype of leader by becoming ‘male’?

A dilemma implicit in the women’s accounts was associated with their chosen leadership style and mode of working as a chief executive, and how far this was

defined (or indeed affected) by being a woman. As noted earlier in this chapter, six of the women had adopted a pragmatic response to the conundrum of how to combine family and working life when in a chief executive post - their partner had chosen to carry out paid work from home, part-time, or not at all, in essence becoming what might traditionally have been considered as a 'wife' to the chief executive. In this way, the women were able to work 'as if a man', devoting themselves to long hours and more than full-time work, family life effectively being pushed to the margins of their available time. Similarly, the management culture of the NHS, with its requirement of conformism to central policy priorities, avoidance of challenge, and suppression of personal values that conflicted with central direction, was criticised by many of the women, but in reality they were 'towing the party line' rather than seeking to make a challenge to the status quo.

Four of the women, when reflecting on their experience of being a woman chief executive and hence in a minority within the NHS, described how they felt that they had to work harder and be better than men. At the end of her interview, in her final reflections, chief executive G noted:

'I feel really proud of being a woman chief executive. My daughter tells me that women's equality is nonsense for we are all equal. But I realise that I have done well to survive. I know that to continue to survive, I've got to continue to be better than men. We will know we have got true equality when mediocre people are appointed to top, mediocre women are appointed to top jobs, like mediocre men are...'

Chief executive I likewise asserts that things are, in her view, tougher for women than for men, framing her comments as part of a feminist struggle:

'Any woman who has got a fantasy that the ceiling is broken, that the battle is fought, you hate to be thought of retrograde in some way or pretending a problem is there that isn't, but actually, I am thinking, you know, watch your

footing all the time, my dear. We had to be battleaxes didn't we, to get armed with all this? I just hope the next generation know enough about it, and if they don't need it that is fabulous, and if they do need it I hope it is there.'

Others were less sure about this, expressing a sense that perhaps things were now tough for men and women chief executives alike, especially in the climate of financial restraint and high demands of service performance from politicians, senior managers and the public. For example, chief executive C noted:

'A lot is made of women having to work harder than men. I think that was the truth when I started as a chief exec, but think that these days is hard work for everyone and if you want a balance with rest of life, you have to work hard to find it. There's no extra requirement on me to work harder than the men now.'

For seven of the women, the issue of why women might lead differently from men was a matter of personal values and choice, and they extended this argument in order to provide an explanation of why fewer women than men had become chief executives. Chief executive H commented:

'Compared with a lot of my university peers, I have not experienced the overt discrimination of those who went to work in other sectors. A lot of the issues about why women are less successful than men is about women and what they choose to do and valuing things differently.'

She did however go on to recount how, in one post, she had felt a need to 'be like a man' in the prevailing management culture, a theme that is returned to later in this section:

'There were times in that job when I felt like I almost had to become male to do it and adopt some of their behaviours to do it, and there were times when that was quite difficult. Interestingly, the time it was least difficult was when I was pregnant and then they decided to be nice to me. It was weird, but you had to be almost better than anybody else...it was a constant battle for the two of us [me and the director of nursing] and we were both young women, and all the others, apart from John [the chief executive], who was probably ten years older, all the others were a lot older than us, had been there donkeys years, had worked their way up the greasy pole, they didn't like graduates, if they had to be graduates at least they could be a man....'

Chief executive A considered that personal choice was a more dominant driver of the number of women in chief executive posts than gender per se:

‘I find it interesting that I get interested in being interviewed as a female chief exec, and wonder if that happens to men at all. It comes back to whether it is gender specific or about people exercising choice. When I look at the women chief execs I know, they have been no less career-driven or motivated than their male counterparts, but they have exercised choices.’

She had made similar assertions about women’s choices in relation to senior posts earlier in her interview:

‘I don’t know why there are not more women in large hospitals, for I find the job quite easy to do. I think some women bring it on themselves and don’t aspire to the top jobs....I think they opt out of the competition’.

However, chief executive H went on to reflect on the impact of child-bearing on a woman’s role as a senior manager, and apparently contradicts her statement about personal choice by asserting a need for the NHS as an organisation to change how it constructs leadership roles, so that part-time or job-sharing arrangements become possible:

‘Having a child takes a couple of years out and stalls things for a while. I don’t think there is prejudice about that. But I would love to work part-time, four days a week, but just know it is not possible. I get best of both worlds by working at home on Fridays as frequently as I can. But we need to make it possible for women in top management to work part-time or job share. That is not there at the moment, nor does it feel possible. But sometimes it is women who say it is not possible, or perhaps it’s a system issue that the jobs feel undoable unless you are prepared to work very long hours.’

Chief executive J, who talked about some of the guilt she experienced as a working mother, reflected on women in leadership roles by asserting a need for women to be a role model for other women in respect of how to do things differently:

‘In the NHS, as a woman, it is still reasonably macho as a management profession, but in this position I can be a role model and show that you can run

a 24/7 service and do lots of different things and have a life as well. I try to show that we can be a lot less rigid about the way we do things, show greater flexibility in organising things around the needs of the patients and also of the people who work with them.’

Others, such as chief executive D took an apparently matter-of-fact position that implicitly accepted the prevailing model of and NHS chief executive role, explaining that women could not ‘have it all’ and had to make inevitable choices between their roles as mother and chief executive (see quotation on pages 238-9).

Chief executive B, who did not have children, reflected on women’s style of leadership by setting out views that appeared to contradict themselves, at once asserting women’s skill and need to work harder than men, and yet also pointing to what she considered to be a tendency to manipulate people and get away with it:

‘But women are harder to work for – you cannot trust them. We manipulate things to our own ends, more than men, without doubt. I can work with women I trust and know. A gender balance helps – all women together is awful, and all men together – they just pontificate. It needs a healthy mix. Female chief execs are definitely more manipulative and they get away with it too. But we have a harder life and have to be better than men. We need to keep proving ourselves all the time, and when you look at it, women tend to prefer working for men.’

This ambivalence about how far to ascribe difference to women’s leadership style or not, and if so, whether or not to say such difference was in their gift, was echoed by chief executive J when reflecting on the long hours culture in the NHS:

‘As the NHS gets more commercial, we need to find ways of finding jobs interesting for women and how they like to work. All these breakfast meetings are nonsense – organisations have to be able to cope without you for a few days. Women are their own worst enemies in some ways – there needs to be an absolute spread across all services but there isn’t.’

These accounts of being a woman in a man’s world bear witness to some of the uncertainty or even ambivalence demonstrated by some of the women when talking

about the gendered nature of their experience. The area of potential conflict appears to be one that is concerned with whether or not being a woman is in itself a discourse that contradicts the discourse of being an NHS chief executive. From the narrative extracts set out above, it appears that this is indeed contested and complex territory. Women chief executives apparently hold differing views about the significance or otherwise of their gender to their role as chief executive, and in some cases a particular woman may express contradictory views about gender and leadership within the space of a few sentences.

Five of the women made explicit reference to an attempt to ‘act like a man’ in order to make progress within NHS senior management. In this way, they were acknowledging their acceptance of a need to accommodate and adapt to the prevailing organisational culture as a way of making personal career progress. For example, chief executive G commented:

‘I have always been completely at home with men and always thought I could do what men could. Up until I appointed two senior managers when a chief executive, I had always been the only senior woman anywhere I worked. The NHS Women’s Unit showed me how to be ‘masculine’ (to be more masculine than men to be accepted), but I have adapted that. [...] Many male hospital chief executives are competitive and very transactional, treating the job like the general who controls the army. They fill the leadership frame themselves. I am transformational and those men see this as very much the weaker style, but I have adopted this because I cannot do the stamping around stuff.

It is interesting to note that this chief executive acknowledges her adoption of ‘masculinity’ to make progress in her career, and yet also explains how she practises what she sees as a more feminine style of leadership, notably transformational (as opposed to transactional) leadership. She also asserts that she has been able to be ‘male’ in her approach to family life (where her husband gave up work to be a full-time home-maker):

‘They are really well-adjusted young adults – my husband did a fantastic job bringing them up. I don’t think I could have done the work that I have done if I had bought in childcare. I see the challenge it gives to people – I was like a male chief executive really in that the childcare was always there and I could come home late if I had to. I take my hat off to women who manage it.’

Chief executive I makes a similar comment about ‘being like a man’ in being free of childcare responsibilities:

‘As I haven’t had children, I have never had geographical constraints in developing my career nationally. For women, there are a lot of limitations around their domestic responsibilities – in that way, I have been more like a man, and where the job is, I go.’

Chief executive E echoes chief executive G’s thoughts about women’s style of working, commenting on what others consider to be women’s particular aptitude for chief executive posts in primary care and mental health organisations, revealing both disdain for these being cast as ‘women’s work’ and then asserting the specific value that women bring to such roles:

‘There are more women in PCTs and mental health trusts for it is not considered a real man’s job, yet I think acute trusts need something different from a man in a grey suit, to manage a complex system. [...] There is a perception out there that it can’t be hard to manage a mental health and/or primary care trust.’

One woman, chief executive D, went as far as to assert asexuality in how she performed her role as a chief executive, comparing herself with other women who she considered to have used their gender to their advantage in the workplace:

‘I don’t really think of myself as a woman at work, even if I am the only one there. I am almost asexual. I have seen other women try and use feminine charms to get things done, but I never do that – it never occurs to me. I suppose that is a difference about me, I would say, you know I am not, I don’t, you wouldn’t think of me as a woman necessarily, it would be interesting to ask other people if they think of me as a woman – I am sure they do, but I don’t think of myself as a woman, you know I don’t, which is interesting isn’t it, I haven’t really thought about this before.’

However, the sense of dilemma about the degree to which gender is an issue, and she has faced specific challenges as a woman, immediately recurs after her assertion of asexuality, as does her reference to sponsors as enabling her progress:

‘I suppose having a family and being a woman, I have made compromises, but it has not particularly got in the way of me being able to succeed in my career, if I am brutally honest, compared with many women. I have been extremely fortunate in my opportunities I have been given, probably because of the people I have worked with being enlightened about women having a contribution to make in the workforce – I have not worked with MCPs.’

What is clear is that the women have all assumed a more or less pragmatic position in relation to the model of leadership apparently required by the NHS. They all worked full-time, for long hours, and had, with two exceptions (chief executives E and A), got partners who were assuming the major child care and home-making role within the family. Despite criticising NHS management culture for its demanding and unforgiving nature, all of the women were operating in this culture, or opting to abandon it altogether, as with one who was about to emigrate and another who was considering not returning from maternity leave. When reflecting on gender and leadership, some of the women asserted that ‘it was different for women’ and that more needed to be done in respect of enabling different patterns of work that were more ‘family-friendly’. However, this was tempered by comments about women making their own choices about their careers, ‘being their own worst enemies’, and preferring to work in a manner that might be more appropriate to certain types of non-acute or smaller organisations.

This dilemma of leadership archetype was complex and hard to pin down during the process of narrative analysis. It was, however, strongly recurrent, unsettling in its contradictions, and often expanded upon at some length by the women in the

conclusion to their interview, in response to the ‘is there anything else you would like to add’ question. Furthermore, once the tape recorder had been switched off, and the interview officially over, the theme of women in leadership was the one most frequently discussed by the woman with the researcher.

Chapter summary

The six dilemmas explored in the chapter reveal some of the themes and preoccupations that emerged during narrative analysis of the women’s ‘story of career’. The analysis sets out some of the ‘whats’ within their stories: their perceptions of luck and good fortune; the role of male sponsors; their approach to reconciling motherhood and career; the impact of their career and childcare choices on their partners; the challenge of reconciling organisational and personal values; and the model of leadership within which the women choose to operate, given the prevailing management culture in the NHS. As well as these ‘whats’, the exploration of dilemmas preoccupying the women points to some important ‘hows’, such as paradoxical ascription of luck and hard work to a single achievement, oscillations back and forth in a single narrative between commitment to career and a desire to be a ‘good’ mother, and assertions of a wish to operate ‘differently’ as a women chief executive (e.g. working more contained hours, adopting a more consensual and networking style) while also being thankful for home arrangements which enable a working life that is ‘like that of a man’.

What is clear is that the women, in telling their story of career and self, reveal, through a process of narrative analysis being applied to their accounts within a pluralistic and primarily dialogical approach, a complex, paradoxical and puzzling

existence. The opportunity to talk about themselves, and in so doing to craft selves, reveals multiple and shifting selves within stories that seek to make some overall sense of the experience of being a woman chief executive in the NHS in 2006-07. In the next chapter, the six dilemmas are explored in depth and considered within the context of research literature on the different topics highlighted by narrative analysis of this community of stories of career and self.

CHAPTER 7

DISCUSSION

Introduction

This chapter discusses the findings from the two survey questionnaires of NHS chief executives and the in-depth interviews with a subset of ten women chief executives, exploring the overall themes to emerge from this research. The different gender composition of PCT and acute trusts is discussed in the context of the two parallel chief executive populations (provider trust, and purchasing/primary care) that emerged in the 1980s and 1990s, along with a consideration of initiatives that have been put in place to try and increase the representation of women within NHS leadership. This is followed by an exploration of the six dilemmas experienced by women leaders that were identified in chapter 6, this being used as the basis for examining how women chief executives seek to construct and narrate crafted and selves.

Gender and NHS chief executive populations

The two national surveys of the NHS chief executive population in England, carried out in 2003 and 2006, revealed that women make up 37% of NHS chief executives, although closer examination reveals that 28% of NHS trust chief executives are women, compared with 54% of PCT chief executives. This is significant in that the NHS has a majority-female workforce, and a majority of management trainees entering the national graduate training scheme for the NHS in recent years are female (Saunders, 2006). This suggests that there continue to be barriers to women assuming

the most senior management roles in the NHS, and also that gender is a key difference between the PCT chief executive population and that of NHS trusts.

It is of note that the overall NHS chief executive population has reached the point at which Chesterman et al (2000), drawing on the work of Kanter (1977), asserted that women (or another organisational minority) can 'tilt' or influence the culture of the overall group, namely 30%. The fact that women make up half the population of PCT chief executive posts, but only 28% of trust posts, means that there is now the potential to study the organisational culture of these respective organisational types, in order to test out the 'tipping point' argument made by academics such as Kanter and Chesterman et al. However, Chesterman and colleagues warned of the risk of gender stereotypes being reinforced as women become a larger occupational group, with certain traits and orientations being associated with 'the feminine'. Thus there is a risk that PCTs might come to be regarded as a 'soft option' for chief executive posts, and be stereotyped as requiring certain 'feminine' management traits such as being team-oriented, more inclusive, and having strengths in networking and collaboration.

In 1994, the NHS Creative Career Paths study, a national research project that sought to map the senior management population in the NHS (for more information see Chapter 3) asserted that the typical model for an NHS chief executive was a married man of middle age with a partner who was a full-time homemaker and cared for the children. The research carried out for this thesis identified that in the early 2000s, within NHS trusts over two-thirds of the chief executives were men, whilst in PCTs, women were represented in equal numbers. Data about partners were not gathered, but information about age revealed that 'middle-aged' would continue to form an

appropriate epithet for a majority of chief executives. This suggests that the typical model of an NHS chief executive is changing in relation to gender, albeit slowly and more so in PCTs than in NHS trusts.

That the typical NHS chief executive in the 1990s (and arguably still today in NHS trusts at least) was a white man of middle age is evidence of what researchers into masculinity have termed ‘men’s privilege’ in the workplace. Flood and Pease (2005), in a paper exploring the role of male privilege within organisations assert that

‘unjust gender relations are maintained by individual men’s sexist and gendered practices, masculine workplace cultures, men’s monopolies over decision-making and leadership, and powerful constructions of masculinity and male identity’. (Flood and Pease, 2005, p121)

These authors argue that:

‘naming and critically interrogating men’s privilege, in the context of an intersectional analysis, provides a valuable framework for work towards gender equality in public sector organisations’. (Flood and Pease, 2005, p135)

This suggests that it is important to approach the topic of gender and organisations from a male privilege, as well as a female minority, perspective. Arguably, this approach points towards Myerson and Kolb’s ‘fourth frame’ of seeking to develop gender equity by resisting and revising the dominant discourse, moving beyond the three previous frames of fixing the women, promoting equal opportunity and valuing difference. More fundamental challenges, such as seeking to name and understand male dominance and privilege within organisations, might arguably enable a more critical endeavour in respect of enabling greater gender equity.

As part of the Opportunity 2000 Initiative in the 1990s (see chapter 2 – policy context), there was a national push to try and develop a more diverse NHS senior

management community via ‘fixing women’ to apply and gain senior posts and seeking to enable a workplace culture of equal opportunity (namely an effort focused on Myerson and Kolb’s first and second frames). The Creative Career Paths studies, research by Goss and Brown (1991), and the work of the NHS Women’s Unit bear witness to this. However, it would seem that this emphasis on gender equity in the 1990s was not sustained within NHS policy, with the NHS Women’s Unit being disbanded in 1996 and amalgamated into a lower profile equal opportunities unit. It appears that the NHS has sporadically taken account of the lack of gender equity in its senior management population, with time-limited initiatives and resourcing. What has been lacking has been a sustained organisational or cultural commitment in policy and practice to changing the demography of the NHS chief executive population, or regarding this as an issue of equity and social justice.

NHS trusts and PCTs as distinct gendered chief executive populations

The most striking element of difference in relation to gender and the chief executive population in the NHS is the different gender composition of the two main cohorts of chief executives, namely NHS provider trusts on the one hand (where women are in the minority, and always have been), and primary care and purchasing organisations on the other (where women and men are now represented equally). There are a number of possible reasons for this difference, including that a PCT chief executive role might call for a different set of skills and experience compared with an NHS trust; that women and men may be more or less attracted to applying for these posts, and that they may be more or less likely to be recruited into certain types of chief executive post. As was noted in chapter 3 (literature review), women have always been represented to a greater extent within the senior management of community

services and primary care organisations than they have within acute hospitals, and in sectors other than health, it has been noted that women tend to be managers in 'less prestigious' parts of a particular industry (Mennerick, 1975).

Assumptions about women's apparent preference for PCT or other community services chief executive roles might include: a style of working that favours networks and relationships, rather than institutions and hierarchies; a desire to work in new organisations rather than those which are more established; a preference for planning and strategic development over and above operational management; or an organisational culture that is more flexible than that traditionally associated with large hospital institutions. These are, however, purely assumptions, and gendered ones at that, representing a form of sex-role stereotyping as described by Alimo-Metcalfe in her work in the 1980s and 1990s. Furthermore, it is again instructive to reflect on Chesterman et al's (2000) assertion that once a 'critical mass' of women take up senior posts in a sector or organisation, then there is the possibility of changes to management culture and modes of decision-making. It could be that the greater proportion of women chief executives in PCTs is of itself an encouragement to other women to take up leadership positions in that sector, and in turn for the style of management to be appealing to women, notwithstanding the caution sounded by Chesterman et al of the gendered and potentially stereotypes nature of such assertions.

Rosener (1990) concluded from a survey of 'matched pairs' of men and women managers in US organisations in 1989 that women have specific leadership skills that are different from and complementary to, those of men. In 'Ways Women Lead' she asserted that whilst men appeared to prefer to lead in a 'transactional' (Burns, 1978)

manner, women were more likely to describe themselves as ‘transformational’ leaders. She noted that:

‘[The men] view job performance as a series of transactions with subordinates [...] [they] are also more likely to use power that comes from their organizational position and formal authority. The women respondents on the other hand described themselves in ways that characterize ‘transformational leadership’ – getting subordinates to transform their own self-interest into the interest of the group through concern for a broader goal. Moreover, they ascribe their power to personal characteristics like charisma, interpersonal skills, hard work, or personal contacts, rather than to organizational stature’ (Rosener, 1990, p120).

Rosener followed up the survey with interviews with women senior managers and identified what she believed to be distinctive elements of how women lead, namely that they:

- encourage participation;
- share power and information;
- enhance the self-worth of others; and
- energise others.

Rosener attributed this alleged difference to women’s career paths and to socialisation, and asserted that organisations needed to expand their conceptualisation of effective leadership in order to embrace ‘interactive leadership’ which she felt was more associated with women’s preferred leadership styles and which could be particularly successful when practised within organisations. Rosener’s work received criticism in relation to its premise that women lead in a different way to men (see chapter 3 literature review), being regarded as a ‘sell-out’ in some quarters, in that it failed to address the perceived causes of discrimination against women in the workplace, and reinforced gender stereotypes, offering an ‘excuse’ for women being

‘different sorts of leaders’. It is, however, interesting to reflect on Rosener’s work in the context of this research with NHS women chief executives, for one of the women respondents in 2006 chose to define herself as ‘transformational’ in comparison with how they suggested men lead, for example:

‘Many male hospital chief executives are competitive and very transactional, treating the job like the general who controls the army. They fill the leadership frame themselves. I am transformational and those men see this as very much the weaker style, but I have adopted this because I cannot do the stamping around stuff.’ (chief executive G)

Whilst Rosener’s analysis suggests that women may prefer to lead in certain ways, it leaves unanswered questions as to why this might be, and as she herself admits, factors such as socialisation, and career paths ‘expected’ of women, play a part in determining where and how women choose to work and lead.

Some of the chief executives in this research asserted that leadership in acute trusts was by its nature different from that required in PCTs, explicitly or implicitly referring to trust management as being more ‘macho’ or transactional:

‘People in acute trusts are much more about doing and people in PCTs are about thinking. I think people in PCTs are less experienced and have got to chief exec posts with relatively little experience of how the health service works. As a consequence, they are less inclined to take risks and make decisions, so there is more circular debate in meetings and forums.’ (chief executive A)

‘My experience of acute trusts is that the complexity is not as interesting as in PCTs, but there is an intensity of working and a culture of long hours that I just don’t want at present. I know you can set an example as a chief executive, but... I was recently asked by the local acute chief executive to come to a meet at 7.30am and I refused, for I just will not go to a meeting at that time of the day. There is that culture, partly around how consultants work, but I am just not prepared to do that now. And PCTs are just more interesting, especially now, with the agenda around making commissioning effective.’ (chief executive H)

Others however claimed that both sectors now required similar experience and skills (compared with the early days of PCTs):

‘My view is that to be a good commissioner, you have to be a damn good strategist. I think I can choose the sector I work in and could do a PCT – acute chief execs are starting to go for PCTs.’ (chief executive B)

Reflecting the criticism of Rosener’s work in relation to focusing on women as ‘different’ leaders rather than attending to the causes of discrimination that might prevent them from being able to lead in certain types of organisation, some of the women in this research reported on experience of how very hard it had been to secure an acute trust chief executive post in the first place. Chief executive G recounted how she had been warned off applying for posts in large teaching hospitals as:

‘the doctors there would never wear a woman chief executive, however good I was. He made it clear that for this part of the world, a woman teaching hospital chief executive would just not be acceptable’.

Likewise, chief executive B described how difficult it had been to secure her post in the face of it having been ‘promised to a man’. This suggests that the issue of difference between PCTs and trusts in relation to the gender make-up of the cohort may in part be due to some women experiencing discrimination when seeking to be employed in trusts, and in particular large acute hospital trusts. One can only surmise that this might in turn dissuade some women from applying for such posts.

That there is ‘difference’ in the trust and PCT chief executive populations in respect of gender is not in doubt. There also appears to be a sense among some chief executives that the two types of organisation might require (or be perceived to require) different skills and approach to work. Given that the numbers interviewed for this study were deliberately small (and all were women), it is not possible to make

firm assertions as to how and why PCT leadership might differ from that of acute trusts, nor why women appear more likely to be attracted to and/or recruited to work in PCTs.

What is clear is that much more sophisticated analysis of the respective roles of PCT and acute trust chief executives (of both genders) would be required prior to reaching conclusions as to exactly why it is that proportionally more women are chief executives of PCTs than of NHS trusts, for this is a phenomenon that has been noted to date back to the 1970s and 1980s. In making such an exploration, work by authors such as Chesterman et al, Mennerick, Acker, Rosener and Alimo-Metcalfe would be helpful in drawing attention to the gendered nature of organisations and the connection with the assumptions made about preferred management styles of both women and men.

The gender difference between NHS trust and PCT chief executive populations, as explained in chapters 1 (introduction) and 4 (methodology), formed the basis of the decision to focus the second phase of this research on an exploration of the role and experience of women chief executives, as revealed in their narrative accounts of career. In the next section, the six dilemmas identified in chapter 6 when presenting the women's narratives are explored in more depth.

What are the dilemmas inherent in the experience of women chief executives?

Given what this research has revealed about the persisting homogeneity of the senior health services management community in the English NHS (albeit that PCTs appear to have a more balanced gender make-up), interviews with a sample of women chief

executives sought to gain an insight into what it is like to be part of the minority of NHS chief executives who is a woman. The focus was on finding out how women made sense of their role as a leader, and how this related to their other roles and selves. In the interviews analysed in chapter 6, six core dilemmas or tensions emerged as being common to the experience of these women, namely:

1. To where or whom should I ascribe my success?
2. How far should I acknowledge the support of male sponsors?
3. How can I reconcile my role as a mother with that of being a chief executive?
4. What have my career choices meant for my partner's role and career?
5. How can I reconcile personal and organisational values?
6. Have I adapted to the predominant male archetype of leader by becoming 'male'?

As noted in chapter 6, these dilemmas were identified as part of a process of narrative analysis that was applied within the conceptual framework deduced within the literature review set out in chapter 3. The stories were assumed to be 'stories of the career as a project of self-management (Grey, 1994), stories that revealed what Kondo (1990) has termed 'multiply crafted selves' and hence located within a dialogical theoretical perspective where selves are continually constructed and reproduced in a

playful, and often paradoxical manner (Mabey and Finch-Lees, 2008). In other words, the crafted selves emerge within a process of story-telling, a performance (or in Mabey and Finch-Lees' terms a carnival) that seeks to assemble identity (or identities) with and for a particular audience. Law (1994) described this process of identity construction as follows:

‘Each one of us is an *arrangement*. The arrangement is more or less fragile. There are ordering processes which keep (or fail to keep) that arrangement on the road. And some of those processes, though precious few, are partially under our control some of the time.’ (Law, 1994, p33, original emphasis)

The dilemmas explored here represent an attempt to understand these arrangements of selves. Through exploring a ‘community of ten stories’ (after Chase, 1995) as well as ten individual narratives, the intention was to reveal patterns within the arrangements, to try and understand the preoccupations of the women chief executives, and through this to determine something about how they chose to construct and present their multiple selves and to explore the anxieties or dilemmas inherent within this. As the women performed their gender (Butler, 1988), and reproduced and crafted their selves, so certain concerns appeared to recur, concerns that presented themselves as dilemmas troubling some or all of the women. These dilemmas are explored in more detail in the sections below.

1. To where or whom should I ascribe my success?

The women chief executives in this research revealed a dilemma in respect of to where or to whom they should ascribe their career success. Studies of performance at work have identified that women’s achievements are more likely to be ascribed to luck (an external factor), whereas men’s achievements of the same tasks are more likely to be ascribed to skill (an internal factor) (e.g Deaux and Emswiller, 1974;

Nieva and Gutek, 1980; Wallston and O'Leary, 1991). In this study, it was apparent that the women chief executives did indeed demonstrate a tendency to ascribe their career success to luck, albeit that some of them also described conscious planned steps that were taken in order to achieve promotion and development.

Whilst in the 1970s and 1980s this ascription of women's success to luck was reported as being something that others, or performance managers did in relation to women's progress, by the 1990s, work on sex-role stereotyping (e.g. Alban-Metcalf, 1989, Alimo-Metcalf, 1991; Gaskill, 1991; Diaz de Chumaceiro, 2004) suggested that women themselves tended to perceive that reaching a senior level in their chosen profession was related to an element of luck. Alimo-Metcalf, in a paper in 1995 that explored male and female constructs of leadership, observed a tendency on the part of women to talk down their talents, defer to others, and to ascribe their success to luck or others, something that is evident in some of the stories told in this research.

However, she noted that when things go badly wrong, women tend to blame themselves, whereas male managers were likely to attribute success to their own ability and their failure to bad luck (Alimo-Metcalf, 1995; Maddock, 1999).

In some of the assessments that the women chief executives in this research made of themselves and others, they demonstrated a certain degree of ambivalence in relation to reasons for achievement, moving from assertions of women being lucky to have made progress, to others about skill and competence being the reason for success. Similarly, when talking about their experience of workplace discrimination, some of the women cited personal discrimination and called for a change in NHS workplace culture, yet also asserted that 'women make their own choices' and 'can be their own

worst enemies', implicitly placing blame for elements of discrimination at the door of women. Furthermore, the women expressed some ambivalence about the degree to which (usually male) sponsors or father-figures have been instrumental in their career success, as opposed to a sense of 'I have done this for myself' (for further discussion of this issue see next section). This apparently contradictory behaviour echoes Ford's (2006) analysis of senior managers' discourse, noting the complex shifts between and parallel presentations of macho-management, post-heroic (transformational), professional and social/family discourses during narrated accounts of work and career experience.

This dilemma about the ascription of success, along with those related to discrimination and to sponsors, goes to the heart of the debate about gender, work and organisation. It begs a question as to whether it is the responsibility of women to determine their own career progress based on merit, or if the organisation should take steps to enable women's development and promotion. However, both such approaches would represent 'fixing the women' or 'enabling equal opportunity' in Myerson and Kolb's (2000) terms, and would stop short of change 'from the fourth frame' that would entail a more fundamental challenge to workplace culture and leadership approach. Ford (2005) appears to take up Myerson and Kolb's challenge in her analysis of leadership in the NHS, calling for the NHS to develop a different approach to leadership that enables both men and women to display a range of masculine and feminine workplace behaviours, to work with (and not against) the dilemma of luck/competence or sponsor/self-merit, seeing such a dilemma as a rich and culturally sensitive approach to management, one that celebrates, rather than dismisses, complexity and ambiguity, and is able to take account of the actual

experiences of men and women in organisations, as opposed to trying to fit them into an ‘iron cage’ of the ‘ideal leader’ (an idea that echoes Gordon’s [1991] work about women becoming ‘prisoners of men’s dreams’).

This ‘both, and’ approach demonstrated by the women chief executives in ascribing success to luck as well as competence has been conceptualised by Bruni and Gherardi (2002) as ‘gender switching’. This was regarded as an inevitable consequence of women seeking to join a particular professional community of practice (such as in the case of this research, NHS management) and seeking to perform their gender identity in a male dominated environment. They note that:

‘aligning a gender identity and a professional identity requires competence and experience to cope with the requirements of the ‘dual presence’, i.e. the ability to stage both a professional self and a gendered one. This ability will be described as competence in gender switching, i.e. positioning oneself discursively as the masculine subject, or not, according to the situation at hand.’ (Bruni and Gherardi, 2002, p176).

Gender switching is asserted by Bruni and Gherardi to be a skill that is needed in order to manage the tension that will inevitably be experienced by a woman seeking to perform a professional self in a male dominated work environment and describe how:

‘when competence in crossing gender boundaries is achieved, then the practicalities of how to do it and the associated emotions become ‘black boxed’ and the tension comes to a closure’ (op cit, p176).

Holmes and Schnurr (2006), in an analysis of how senior women manage and interpret the notion of ‘femininity’ in workplace discourse, drew attention to what Bakhtin (1984) called ‘double-voicing’, a concept that describes how speakers mingle components of different styles for particular effect. Holmes and Schnurr assert that their research demonstrates how senior women:

‘typically drew skilfully and competently on a wide range of discourse strategies, some regarded as indexing conventional masculinity, and some as enacting normative femininity, to accomplish both their transactional and relational goals’ (Holmes and Schnurr, 2006 p42).

This raises the possibility that the women chief executives, when engaging in a discourse of luck as well as competence, might be deliberately employing a range of strategies in order to enact what they consider to be both feminine and masculine approaches to leadership. Indeed, within a dialogical theoretical perspective, women may thus be reproducing multiple selves in a manner that is at once paradoxical and deliberate, or even at times knowingly playful, as pointed out by Mabey and Finch-Lees (2008) in relation to the ‘carnival’ metaphor of a dialogical approach to leadership and management research.

The dilemma of where to ascribe one’s success can therefore be seen to be part and parcel of the dilemma about performing a professional self or selves within a gendered organisation, and in particular (for a woman) in a context where men are in the majority. The observed ‘double-voicing’ or ‘gender switching’ comments that reveal conflicting views about luck as opposed to competence, are thus arguably a manifestation of a more profound tension related to contradictory and multiple selves that are required to be performed in the workplace.

2. How far should I acknowledge the support of male sponsors?

In addition to ascribing career success to luck or happenstance, eight of the ten women mentioned the role of significant (usually male) sponsors in enabling their career progress. A ‘sponsor’ in this context was a senior manager who had assumed an advocacy, patronage or otherwise supportive role on behalf of the woman who was

a career subordinate. This typically involved: identifying the woman's potential and encouraging training, career development, and applying for management posts; spotting the woman and then getting in touch to offer a post; being a boss who challenged the woman and encouraged them to take on greater responsibilities; enabling the woman to combine work and family responsibilities in a way that was uncommon at the time; and taking an ongoing interest in the woman's career over time, being available for advice and guidance.

In the literature about career sponsors, authors such as Kanter (1977) have suggested that the existence of a sponsor represents an alliance that confers power to an individual through others, and hence it is not surprising that some of the women elected to cite sponsors as key figures and actors within their story of career. This element of narration clearly has an element of conferring status and gravitas to the story of self. Kanter describes sponsors as follows:

‘Sponsors have been found to be important in the careers of managers and professionals in many settings....Sponsors are often thought of as teachers or coaches whose functions are primarily to make introductions or to train a young person to move effectively through the system’(op cit, p 181).

Indeed, in the women's narratives, a tendency to cite sponsors in relation to earlier stages of the career was noted when arguably, they may have had most need of assistance in ‘moving effectively through the system’, particularly as this was at a time when fewer women were working in health services management. Kanter goes on to suggest three further functions beyond the provision of advice, that generate power for the person sponsored: the sponsor's role in fighting for the person in question; the sponsor's role in enabling lower-level organisation members to bypass the hierarchy; and a role in providing an important signal to other people, a form of

‘reflected power’ (showing that they have senior backing, and that sponsor’s resources are somewhere behind the individual). In the stories provided by the women chief executives in this research, examples of all three functions were identified. There were accounts of sponsors putting forward women for new job opportunities, and helping them to overcome career blocks caused by discriminatory behaviour. Others told of women receiving calls about jobs that were coming up, and of their friendship with a sponsor enabling an interview for a post. The description of senior sponsors lent a sense of importance to their account, for the women clearly knew or expected that the interviewer would know the sponsors and regard it as impressive that these people were part of their career story. Kanter concluded from her research that sponsors were of particular importance to women:

‘If sponsors are important for the success of men in organizations, they seem absolutely essential for women. If men function more effectively as leaders when they appear to have influence upward and outward in the organization, women need even more the signs of such influence and the access to real power provided by sponsors’ (Kanter, 1977, p183).

She went on to cite other research that supported this assertion, including work from the UK that highlighted the importance of ‘office uncles’ for the careers of women in organisations – men who offered advice and fought for women to be promoted (Fogarty et al, 1971). Whilst this seems in some senses an anachronistic view, over 35 years later, the parallel between fathers and daughters in the sponsor-protégé relationship has been noted, so perhaps an element of ‘office uncle’ persists, at least in the career stories of senior women. Kanter offered further caution about this role, as did Auster (1984), noting that it can be harder for women to acquire sponsors, given that senior managers tend to seek protégés in their own image, and that support of women may be regarded as a ‘good thing to do’ (perhaps as part of equal

opportunities policy) rather than being motivated specifically by support of the individual in question.

It is interesting to ponder how far women starting out in senior management careers in the 21st century seek or need sponsorship of the nature uncovered in this research.

Kanter, in a 1993 update to her 1977 work, asserted that there were new demographics of power that had changed images of women in the workplace over two decades as follows:

- from women competing with women to women as allies;
- from women as needing help to women as deserving involvement;
- from women as assistants to women as power brokers; and
- from womanhood as a limiting characteristic to womanhood as a bonus.

However, the women in this study of chief executives talked about the importance of sponsors (and of needing help?) during the 1990s and into the 21st century. In a paper published in 1999 (Wayne et al, 1999), researchers noted the importance placed on sponsorship by leaders in relation to career success. What they termed 'leader-member' exchange, the specific support and sponsorship of subordinates by leaders in organisations, was noted to be related to all three of their measures of career success – salary progression, the supervisor's view of a subordinate's 'promotability', and the subordinate's career satisfaction. The researchers reported their surprise at the significance of sponsorship for career progression, in particular beyond the early phase of a career, and noted:

‘The current study extends the results of socialization studies that have found support for the role of leaders during early career development...by demonstrating the continued influence of leadership on success in later career stages’ (Wayne et al, 1999, p591).

These researchers went on to note that other research (e.g. Burt, 1992) had shown that rates of promotion were enhanced for individuals who established ties with key organisational members residing outside of the immediate work group. Interestingly, in comparison with sponsorship, mentorship is considered in Wayne et al’s study to be less significant in relation to career success, being helpful in relation to career progression, but not salary potential or career satisfaction. However, the researchers point out that this is not consistent with other research that has associated mentoring positively with career satisfaction and salary progression, so they caution against drawing conclusions in this regard.

This does however highlight the need to clarify the distinction between sponsorship (where a senior manager personally supports, encourages, makes opportunities for, looks out for) a subordinate, and mentorship (where a subordinate has sought out a senior colleague from inside or outside the organisation in order to access career advice and support). In the accounts given in this study and outlined in this section, the women appear to be largely referring to career sponsors.

Sponsors are clearly an important part of the career story of a majority of women in this research, and in most cases (but not all), the sponsors of the women were male. Given that in the 1980s and 1990s when these women were forging their careers, few women were in senior management positions and hence available to be sponsors of junior managers, it is not possible to assert that the women specifically found themselves with or sought out male sponsors as a deliberate act – they may have been

in a situation where there were few or no female sponsors or role models available. However, there is a clearly gendered element to sponsor-protégé relationships where the sponsor is male and the protégée female, echoing father-daughter relationships or Kanter's 'office uncle'.

In a paper reviewing literature on the mentor-protégé relationship Bushardt et al (1991) asserted that:

‘mentors, regardless of their gender, utilize predominantly masculine sex-role behavior, and protégés, regardless of their gender, utilize predominantly feminine sex-role behavior’ (Bushardt et al, 2001, p620).

They conceptualised the mentor-protégé relationship within the context of biological dimorphism, with sex roles reflecting different reproductive strategies that evolved by natural selection. Thus they argued that mentor/protégé relationships mimic mating roles in humans (e.g. the use of power/dependency), often leading to sexual themes infiltrating the relationship and causing conflicts that are rarely understood within the limited context of mentoring. Bushardt et al drew numerous parallels between mating and sexual relationships and the mentor-protégé dyad – and asserted that in the male mentor-female protégée relationship there was most likelihood of a sexual theme as mating sex roles and gender were aligned. Whilst matched gender mentoring is suggested as having a potential underlying homosexual theme, it has been asserted in research (e.g. Auster, 1984) that matched gender mentoring is less likely to experience gender-related difficulties.

Bushardt et al also pointed to the potential similarity of mentoring to parent-child relationships and note that authors such as Glover (1986) and Hobbs (1982) suggested that mentors fulfil a father's role in a protégé's development. These authors called for

greater attention to be paid to gender within mentoring, a theme that was reiterated in a later study which examined mentoring in relation to theories including similarity-attraction paradigm, power dependence, and social exchange (Young et al, 2006). What is clear is that sponsor-protégé relationships, as with mentor-protégé relationships, take place within a gendered context and are likely to entail the playing out of certain sexual and family behaviours. That a majority of the women in this research acknowledged the support of sponsors and mentors, citing them key influences on their career development as they made their way into a career that was, in the 1980s and 1990s clearly male-dominated, suggests that the issue of sponsors of senior health services management careers is an issue worthy of further research, as is the question of how different gender-pairings affect the sponsorship experience.

3. How can I reconcile my role as a mother with that of being a chief executive?

For the seven chief executives in this research who had got children, a powerful narrative for all bar one of them was that of the guilt of the absent mother. The women incorporated into their story an expression of regret in relation to being absent from parts of their children's upbringing, even though in almost all cases they had partners who were taking the lead in childcare and home-making. Examples explored in chapter 6 include chief executive C's wish that she had taken longer maternity leaves and worked part-time for a while, chief executive J's sadness at her son's desire for her to be at home more and at his rugby matches, and chief executive H's acknowledgement that she could only cope with having one child, and even then wished she could more often work at home.

Feminist authors have written about how women can find themselves positioned between the contradictory discourses of career and motherhood, something that appears to be the lived experience of a number of these women chief executives. For example, Raddon (2002) explored the ways in which women academics with children exist at the intersection of discourses of 'successful academic' and the 'good mother', a situation which Raddon asserts to have the potential to be both conflictual and yet empowering.

Clearly for some of the women chief executives in this research, such as chief executives J and C, their experience leaves them feeling conflicted in relation to the discourses of successful manager and good mother, whereas others, such as chief executive D and chief executive G, appear to have felt a degree of empowerment and fulfilment from having been able to work out an 'alternative' approach to shared parenting that enables them to be the primary breadwinner in their home, yet knowing that their children are being cared for by their other parent. Raddon (2002) draws on Hughes (2002) in suggesting that the 'selfless [or good] mother' discourse competes with the 'best of both worlds' discourse of the working mother who is seen as 'having it all'. She goes on to suggest that the 'best of both worlds' discourse:

'is characterised by two competing narratives: firstly, that of the independent, strong woman with her own interests and identity outside of the family; and secondly, that of the selfish woman, who places her own needs before those of her children, or perhaps before the choice to have children at all' (Raddon, 2002, p395).

The women in this research, clearly marked out as successful in terms of their career, and in seven cases as being mothers, are arguably located within the 'best of both worlds' discourse. However, the competing narratives of independence/strength as opposed to selfishness appear to underline the tensions and dilemmas expressed by

the women as they talked of their guilt and regrets. This fundamental dilemma expressed by the chief executives in relation to their role as leader and as mother is described by Raddon as follows:

‘a mother must ask herself, is a ‘good mother’ a selfless woman who puts her child first and lives through her children in some sense, or is she economically active, productive as well as reproductive, and forging some sense of an identity outside of her mothering role: or can she be both?’ (op cit, p395)

This research reveals that for the women as individuals, some find their combining of career and motherhood to be a dilemma that expresses itself as a matter of regret and guilt. This may reflect a personal response to traditional gender relations and what women perceive a ‘good mother’ should be, a feeling of being ‘different’ from those women who assume a traditional child-rearing role, and a concern for what this ‘difference’ might mean for their children and families. Indeed, media presentation of working mothers and the alleged impact on their children, often emphasises the supposed negative effects on children, and polarises as ‘working woman bad, stay-at-home mother good’ a phenomenon that has been explored by authors such as Figes (1998), Winstanley (2001) and Wolf (2002). Winstanley developed this dichotomy into one that is rooted in myths and storytelling and is able to trigger almost primeval feelings of guilt in relation to what ‘sort’ of mother one is:

‘the myth of motherhood provides few very stark choices for mothers, limiting our view to one of polarities – the ‘good’ mother and the ‘wicked’ mother, the ‘natural’ mother and the ‘unnatural’ mother....The myths can also become oppressive, something that becomes a weapon women use against themselves heaping guilt and self reproach and monstrous self loathing.’ (Winstanley, 2001, p17)

Winstanley interestingly goes on to assert that the telling of stories about experience of motherhood can be restorative in themselves, echoing the comments made by some of the women in this research (particularly in discussion after the tape had been turned

off) about how refreshing and therapeutic it was to be able to talk of their experiences, tell their story of being a senior manager, and for many of them, of also being a mother.

One solution to the dilemma of being a mother and a senior manager (or career woman or stay-at home, 'natural' or 'unnatural' mother) seems to be for the woman and her partner to renegotiate who does the childcare and home-making, replacing the 'housewife' with a 'househusband' (see next section for more discussion of this). In this way, there is a change to the gender of who stays at home, but no fundamental challenge to the structure and pressures of senior jobs that call for what Cooper (1996) termed 'presenteeism' – staying at work for long hours to demonstrate visible commitment to the job. Simpson (1998) suggested that presenteeism is gendered, and that it is associated with a competitive masculine culture in male-dominated senior levels of organisations. She asserted that such a culture imposes heavy costs on women, who are most likely to notice presenteeism and then feel a need to try and meet the demands of both work and home. Simpson drew on research to point out that organisational restructuring can produce 'competitive presenteeism' whereby managers compete to stay longest at the office, and suggested that this will be more heightened in environments where men are in the majority.

In relation to this research into women chief executives in the NHS, Simpson's analysis may help to explain why women chief executives opt for an arrangement where their partner assumes the majority child-caring role. Given the regular structural reorganisations of the NHS (see chapter 2 – policy context), high levels of turnover of chief executives (see chapter 5), and what is known about the minority

position of women chief executives in the NHS, it is likely that insecurity and competitiveness associated with presenteeism are likely to be significant. Indeed, this may point to one reason why pressures of long hours and presenteeism appear, from this research, to be less evident in PCTs (where women are not in a minority), as was noted by some of the women in their narratives. It may be that the more balanced gender make-up of that chief executive population is, in Simpson's terms, helping to make some small changes to the dominant organisational culture, or that the 'critical mass' called for by Chesterman et al (2000) is enabling a degree of feminising of organisational culture within PCTs. Once again, caution is needed in respect of a risk of stereotyping women into holding certain preferences as to how they work. The dilemma of motherhood and career was made very evident in this research – a question remains as to how far male chief executives might express some similar dissonance between their role as fathers and as organisational leaders, a question not explored in this research.

4. What have my career choices meant for my partner's role and career?

In research carried out into the demography of NHS management in the 1980s and 1990s (e.g. Disken et al, 1987; Goss and Brown, 1991; IHSM Consultants, 1994), the lack of representation by women typically led to a call by researchers for more to be done in relation to enabling more flexible working, improved childcare provision, and other initiatives concerned with providing support to mother wishing to return to or remain in the workforce (Myerson and Kolb's second frame of enabling equal opportunity). Interestingly, the women in this research in 2006 made almost no such call, with the exception of chief executive H who commented:

‘But I would love to work part-time, four days a week, but just know it is not possible. I get best of both worlds by working at home on Fridays as frequently as I can. But we need to make it possible for women in top management to work part-time or job share. That is not there at the moment, nor does it feel possible.’

Most of the women in this research appear to have negotiated and developed arrangements that enable them to work more than full-time and hence arguably ‘as a female man’ (Marshall, 1995), and interestingly, for six of the seven women who were mothers, this had been via the assumption by their partner of the primary childcaring role. This suggests that a common response to the dilemma of the guilty absent mother is to negotiate with the father of the children in order to reach an arrangement whereby the father will assume a role that approximates to the ‘housewife’ role traditionally occupied by women who are the wives of men working full-time outside the home.

In this way, it appears that women feel able to work full-time and yet assuage at least some of their maternal guilt by knowing that the childcare is being provided by the other parent and not by a third party carer. It is interesting to note that in a number of cases in this research, this negotiation of roles had taken place once the children were beyond the early years of childcare. This appeared to be on account of a sense of growing dissatisfaction with ‘contracting out’ care and also the increasing pressure and working hours associated with more senior management posts that led couples to renegotiate the ‘chief breadwinner’ role. The higher salary associated with a chief executive post was also clearly an enabler of such a shift in family responsibilities.

One way of exploring this emerging phenomenon is to start from an examination of research that has considered the role of the full-time wife or homemaker. In Men and

Women of the Corporation, Kanter (1977) examined the nature of corporate power, in particular in how it related to women. She looked at the careers and self-images of managers, professionals and executives, and also those of the secretaries, wives of managers, and women looking for a way up through the organisation. Her study was based on an extensive research project in a major US corporation, and sought to explore the role of men and women in organisational life. As part of her study, Kanter identified a category of 'corporate wife' to describe women who focused on child rearing, home making, and support of their husband's career. She quoted Henry in saying of the wife's role at senior levels of organisational life:

'a kind of high-class assistant, bound by marriage rather than salary but otherwise facilitating the work goals with the same sense of efficiency the husband would expect of his secretary and other office personnel. The all-embracing demands of corporate life do not permit distractions.' (Henry, 1967, p270)

In exploring the implications of the corporate wife, Kanter notes (p123) that 'some writers have commented that a denial system operates to minimize attention to the contribution made by wives to their successful husbands', either due to a male tendency to claim individual credit for achievements or because of 'the fragility of male self-esteem'. (Papanek, 1973)

What is interesting in the research undertaken in this study in 2006-7 is that the husbands of successful women appear similarly marginalised or even silent within a number of the stories of career, their existence often only being revealed after interviewer prompting about the effect of career upon home and children. The reason for such silence is a point for debate: whether this is due to some form of embarrassment or discomfort on the part of women (and perhaps the men themselves) at transgressing traditional family roles; or related to women becoming 'female men'

(Marshall, 2005) where family and caring responsibilities are expected to remain invisible, as gender does a 'disappearing act' (Fletcher, 1999). The silence of partners might also be revelatory of the fact that these women have spent their careers working within what Sinclair (2007) terms the 'dominant account of leadership' that tends to leave emotion, bodies, sexual identities, family background and other unconscious dynamics out of the discourse and practice of leadership.

In a 1993 afterword to a new edition of her 1977 book, Kanter reflected on the key shifts in emphasis over the past two decades within corporate jobs and careers. One of the shifts she described was 'from homogeneity to diversity: the new workforce. She asserted that occupational sex segregation had declined and that:

'women achieving power through new routes [were] already altering traditional views of differences between men and women, creating new images of women-as-leaders' (Kanter 1993, p291).

She pointed to the rise in dual-worker couples, the issue of 'time crunch' for such families, and asserted that one of the major changes to have taken place within corporate life was the shift from corporate wives to working parents.

The new research reported in this thesis suggests a new phase of social development within families in the 2000s where the woman has a senior leadership career. It appears that we are witnessing the emergence of a 'corporate husband', beyond Kanter's 'time crunch' generation where both parents struggle to have fulfilling careers, where instead it is the man who gives up his paid employment to care for the children and home, or elects to work part-time or in a home-based job, in order to be the primary childcarer and homemaker.

Despite the apparent silence of stay-at-home fathers, there is an emerging literature on the experience of these men, albeit that it remains somewhat marginal in relation to the extent of analysis and comment on mothering. Gatrell (2007), in a paper exploring the negotiation of parental entitlements within marriage asserted that men are increasingly seeking to have an active and involved role as co-parent with their partner, in contrast to previous studies (e.g. Warin et al, 1999) that suggested men were content to be the ‘parent of second contact’. Gatrell argues that this desire for increased involvement may be related to gender-power relations within marriage, asserting that within dual-career couples, men may be threatened:

‘by the challenge posed to male privilege by maternal employment [...] married/co-habiting fathers may defend male dominance by asserting their rights in a sphere previously considered to be a woman’s preserve: childcare’ (Gatrell, 2007, p370).

In the research with women chief executives reported here, a sense was not gained of men taking on childcare responsibilities as part of gender-power relations, but of course the narrative was that of the mother, and the perspective typically one of gratefulness and admiration for the partner who was prepared to make career sacrifices to enable her full-time commitment to her chief executive role.

Determining the gender-dynamics of the particular relationships would require the eliciting of the partners’ as well as the chief executives’ stories of career and self.

In a study of fathering in Sweden and England (Plantin et al, 2003) it was noted that whereas in Sweden ‘involved fatherhood’ had become part of the mainstream and accepted discourse, in England the situation was more complex with class differences (middle class men being more likely to be involved fathers) albeit that evidence was found of unemployed working class men assuming the childcare and homemaker role.

These authors disputed the argument that men are seeking to assume greater control of parenting as another example of male hegemony, suggesting instead that within patriarchal structures, men were increasing their involvement in family life and would so to a greater extent if social policy initiatives were put in place to support this.

A study of 70 stay at home fathers in Canada (Doucet, 2006) revealed that stay-at-home fathers tended to combine parenting with other activities such as part-time work, community service, and education, asserting that in the same way that women 'weave' (Garey, 1999) complex patterns of employment and motherhood, so men are building new models of parenthood and employment. Doucet suggests that the 'social gaze' (reminiscent of Foucault's gaze in relation to the construction of self – see chapter 3 literature review) of community and social networks plays a significant part for men who stay at home to care for children, whereby having to 'trade cash for care' leads them to have to:

'justify this decision to their peers, kin, work colleagues and community onlookers, who cast a critical lens on this disruption to the smooth functioning of contemporary gender regimes' (Doucet, 2006, p295).

Doucet argues that the definition of domestic labour should be widened to include community service, sports coaching, non-routine repairs (do-it-yourself activity) and so forth, to allow visibility to the contributions men make to domestic economy in addition to the traditional tasks of mothering and homemaking. In community service, school sports and so forth, Doucet asserts that stay-at-home fathers may find a comfortable fit between their gendered upbringing, sense of masculinity and fathering. She calls for further research into the identity and selves of men who stay at home to care for children, and also asserts that men could play a role in bringing

greater social recognition to the role of unpaid work. However, Doucet concludes by confirming the marginal and largely silent voice of such men in society:

‘these stories are marginal ones; they sit quietly on the borders of most men’s lives in most contemporary societies [...] We are reminded of the need to move beyond these vignettes of everyday caring and the generative changes that ensue to focus on wider social relations and the need for greater structural changes and policy measures to assist both women and men in achieving work-life integration’. (Doucet, 2006, p297)

Doucet’s work reveals something of the story of stay-at-home fathers and of the narrative they are creating as they seek to build roles that are different and unusual within social networks and communities. The research reported in this thesis has highlighted that for a majority of the women in this study, a ‘corporate husband’ or stay-at-home father has emerged as the ‘deal’ struck between the chief executive and her partner in relation to child care and home-making. Whilst further research into the men’s experiences and stories would be needed to gain a fuller picture of this pattern of family life, it is of note that the arrangement seems to have been in place in order to enable the women to ‘work like men’ in their chief executive roles, in effect operating a form of ‘gender switching’ in the home.

In this way women senior managers are arguably challenging traditional gender relations, seeking to have a strategy that allows them to work in a senior career, yet attempts to enable their children to have the presence of parenting that has traditionally been associated with the role of the ‘stay-at-home mother’. However, it should be noted that the ‘corporate husband’ arrangement could be viewed as being an accommodation of the existing work-childcare paradigm and model of leadership, whereby the gender of who stays at home changes, but the fundamental requirement of a senior manager to work more than full-time and be unable to devote much time to

parenting, remains. This issue is explored further within the sixth and final dilemma below.

5. How can I reconcile personal and organisational values?

A dilemma that resonates through the stories told by the women chief executives is one that concerns dissonance between their personal and organisational values. This dissonance expressed itself firstly in relation to the prevailing NHS policy direction, and its apparent conflict with the value base of the women regarding their public service ethic and commitment to universal welfare provision (social justice).

Secondly, some of the women expressed antipathy towards what some described as masculinised management culture of the NHS, and the resulting ways in which senior managers in the health system were sometimes treated with disrespect, or even bullied, by those in senior positions in strategic health authorities and the Department of Health. The women asserted a belief in a different, more human and enabling (and for some, more feminine) approach to managing people, and explained how they sought to model a different culture (from what they considered to be the prevailing national one) within their own organisation. In relation to both of these areas of dissonance, the women talked about strategies for subversion and resistance (after Collinson, 2003), namely the ways in which they had sought to stay true to their personal values, whilst being able to remain in senior management roles within the NHS.

The dissonance of national policy and personal values

The fact that a number of the women expressed unhappiness about the policy direction of the NHS, typically in relation to the focus on markets and the use of

private sector providers and commissioners, was expressed as ‘something that dared not speak its name’ in anything other than a confidential setting such as the research interview. The women were clear that it would be regarded as both disloyal and a ‘sacking offence’ to speak out about their concern about elements of government policy such as the use of private commissioners, pressure to purchase private sector hospital capacity, and the perceived need (by the Department of Health and strategic health authorities) to reduce overspending in the health system above all else. In this way, they were demonstrating a fundamental loyalty to the organisation, apparently unwilling, in Hirschmann’s (1970) terms to exercise ‘voice’ in relation to complaining about aspects of policy and culture with which they were unhappy, nor (with the exception of chief executive C who was about to leave the NHS, and possibly chief executive F who was considering not returning from maternity leave) were they prepared to ‘exit’ the NHS.

This calls into question the role of senior managers in public service organisations and the extent to which they are, or should be, free to speak their mind and to comment on policy direction. Blackler (2006) examined this issue in a paper that reported on his work in 2000-2001 with a cohort of experienced NHS chief executives noting from his research:

‘the interviews indicate that chief executives’ criticisms about the way the government was managing the modernization of the NHS ran deep. So critical were they indeed that that the question arises about whether those interviewed were especially disaffected and if they were overdramatizing their concerns. There is little doubt that over the time of the interviews reported here tensions between government politicians and senior public servants were growing.’ (Blackler, 2006 p14)

Blackler's observations suggest that the dissonance raised by the women in this PhD research are not specifically gendered in nature, but are likely to be common to the wider NHS chief executive population in the early 2000s.

Concern about the potential for New Public Management, with its associated focus on a more entrepreneurial approach to management in the public sector, to lead to the undermining of the public values traditionally associated with public service, was articulated by Stewart and Walsh in a paper in 1992, at the time of the Thatcher government's internal market reforms in the NHS. These authors cautioned:

‘There has been...an emphasis on a commercial culture with a resulting search for an entrepreneurial approach. There are dangers if that emphasis leads to a neglect of the values of the public domain.’ (Stewart and Walsh, 1992, p516)

Research into NPM and the role of the public manager has often focused on how public managers can be made accountable for their actions and assuring public confidence in them, asserting that ‘political engagement is inevitable’ (Kalboolian, 1998, p191). However, there seems to have been less research that has focused on the individual experience of public managers in this regard, namely how they have made sense of the need to build public confidence in their actions, perform the requirements of entrepreneurial NPM, *and* feel that their personal integrity is preserved. An exception to this was Kettl (1997) who in a review of what he called a ‘global revolution in public management’ described the fundamental dilemma that is posed for the public manager in a situation of reform based on market philosophy:

‘This creates a genuine dilemma for reformers. On the one hand, the reforms seek smaller and more efficient governments, driven by market-based incentives...The temptation is to impose highly stylized images of private management on government agencies, such as tough output guidelines. On the other hand, the job of managing government is more than just a production

function. It requires a sense for and a sensitivity to the public interest.’ (Kettl, 1997, p454)

The chief executives in this research expressed a keen desire to remain true to public service values that had initially led them into health management, yet talked of feeling pressure to be seen to support, and enact, policy that was focused on a market approach to the purchasing and provision of health. Seemingly, their sensitivity to the public interest was, at times, feeling to them to be compromised. To speak out against such pressure is, however, extremely difficult, and examples of those who have done so in the public sector demonstrate the personal risks that such an approach can entail. For example, some whistle-blowers in the English NHS have paid a significant cost in respect of their personal reputations and careers, as evidenced by the case of Graham Pink, (a nurse who spoke out in the press about neglect in older people’s care and was sacked as a consequence), and Julia Drown (a senior finance manager in the NHS who talked publicly of pressure put on finance directors to ‘fiddle the figures’, and who left the NHS in protest at this). Maddock (1999) asserts that women face even more of a risk than men when blowing the whistle on management culture and practice, citing examples such as Wendy Savage (a consultant obstetrician who challenged mainstream medical obstetric practice and campaigned within the English medical profession for a woman’s right to choose how she gave birth) and Helena Daly (a consultant haematologist who sought to change working practices within the hospital where she worked, faced resistance from colleagues, and was dismissed on the grounds of personal misconduct) to support her argument.

Blackler (2006) cautioned against assuming that all NHS managers subscribe to a public sector ethos as described by Pratchett and Wingfield (1994) as accountability, honesty, impartiality, loyalty to community and so forth. Instead, he suggested that

the NHS chief executives held a strong performance orientation to their work which was concerned with public *service* which also focused on service quality and organisational efficiency. Blackler went on to emphasise the importance for NHS chief executives of being able to exercise some ‘bureaucratic discretion’ in their work, and noted that in a climate of an emphasis on rigid rules, these executives could feel undermined and might even be unable to ‘lead’ at a local level, having to implement central policy when having little room for manoeuvre. He also drew attention to what he considered to be significant mistrust by politicians of public sector managers, something he felt to be particularly acute at the time of his research.

It should however be borne in mind that Blackler was working with a specific cohort of chief executives, namely a sample who had been chief executive for at least seven years (the criterion for entry to the development programme Blackler was running – the programme from which he drew his sample), when only a third of chief executives met that requirement. His interviews with 25 chief executives took place over a period of two and half years and no mention is made as to whether the respondents were men or women. Blackler acknowledges that his cohort were inevitably experienced chief executives, many of whom had been working in the NHS for long periods of time. This could arguably account for some of the degree of discomfort expressed by the chief executives about the style and policy direction of the Blair government, given that many of this group had worked as senior managers under earlier administrations when, as Blackler suggests, public servants were subject to less central direction and performance management that was the case with New Labour.

This tension in the role of the public sector manager between implementing government policy (i.e. acting as a form of civil servant) and responding creatively to local circumstances (i.e. being a local leader or champion) was highlighted in work carried out by Andrew Wall (1998) into ethics and health management. Wall pointed out that managers are fundamentally accountable to others, in particular the public and government, as well as being responsible for the use of public money and ensuring that the law is upheld. He used the example of financial pressures as a situation where a manager is likely to have to take actions which will may not be regarded by staff as ethical (e.g. making compulsory redundancies, closing hospital beds) yet fulfilling performance requirements set by the government of the day and its agents. Wall summed up the complex (and often conflicted) situation faced by health managers as follows:

‘Managers are faced with contradictory pressures: obedience to their masters, support for clinicians, maximising public benefit, respecting the rights of patients; all these can be, at times, in opposition. [...] Nevertheless they may be hesitant at declaring their own values, fearing derision for being too subjective and not therefore exemplifying the rational paradigm associated with managerialism.’ (Wall, 1998, pp24-25)

Arguably, at the time of the research with women chief executives reported here, when the NHS was facing a significant financial crisis with accompanying hard-nosed central management, the women were experiencing a similar sense of conflict and lack of managerial room for manoeuvre, as reflected in comments such as those of chief executives I:

‘It is a very demotivating environment in this region at present due to the financial situation and there is a lot of bullying going on. You get people on the phone shouting at you if you have put the wrong number on your financial returns’. (chief executive I)

In a service such as the NHS, which is renowned for its centrally-managed approach (Ham, 2004), it appears inevitable that the culture and pull of the political centre will, when it comes to the crunch, predominate over a desire to serve local people and service users. This dilemma in relation to personal and organisational values, as exemplified by a wish to honour public service objectives in preference to implementing reforms deemed to be contrary to such aims, goes to the heart of debate about the nature of NPM and of what constitutes a public manager in a context where market-based reforms are being implemented. The lesson from this research is that the people charged with delivering reform, the chief executives of public organisations, find themselves in a situation of conflicted values and loyalties, a conflict that they are largely only able to express within the safety of the anonymised research interview. The issue is however in itself paradoxical, for as pointed out by Caulkin (1998, p46), health service chief executives work at the line where ‘planning, improvisation and political pressures meet in a framework of financial and physical constraints’ and are therefore inevitably placed at what Blackler (2006) calls the ‘uneasy boundary’ between central government, health professionals, patients and other interest groups.

The dissonance of macho-management and post-heroic management cultures

A profound discomfort with the prevailing NHS culture was expressed by a number of the women interviewed in this research. Terms such as ‘bullying culture’, ‘over-weaning arrogance’, ‘scapegoating’, and ‘de-motivating’ were among those used when describing their experience of the strategic health authority and Department of Health in terms of style of treatment of chief executives. This echoes Ford’s (2006) macho-management discourse that she identified during a study of leadership within

UK local government, pointing out that despite rhetoric about transformational leadership (a clear parallel to the NHS) the accounts of local government leaders revealed a strong and predominant sense of macho-management behaviour, language and values. Ford describes the macho-management discourse as follows:

‘This approach is represented through more traditional leadership behaviours (embodied in earlier studies of leadership, and reinforcing trait and style approaches), and appears to draw more strongly from hegemonic masculinist discourses of leadership, reinforced through the subject position of a competitive, controlling and self-reliant individualist. The whole notion of leadership is arguably constructed through the leader-follower pairing, with the followers being the (subordinated) other to the leader’s (dominant) position’ (Ford, 2006, p84).

Ford asserted that in order to better understand identity and subjectivity, there was a need to identify the multiple and shifting discourses and positions adopted by individuals. She underlined the significance of context and the socially constructed nature of leadership, and pointed to the ‘performative process of leadership [that] is achieved through a range of exclusionary practices that aim to offer a homogenous definition of what a leader in an organization is expected to be’ (Ford, 2006, p81). She went on to note that one of these ‘exclusionary practices’ was a failure to consider the androcentric nature of organisational life, thus adopting a critical management discourse that regards the gendering of organisations as associated with power and control.

It appears that for the women in the research reported here, they experience and express a discourse that echoes Ford’s macho-management, albeit that the NHS Leadership Qualities Framework attests to a belief in transformational and enabling leadership (NHS Leadership Centre, 2002). Whilst Ford (2006, p87) presents transformational leadership as a ‘postheroic’ discourse related to ‘a more distributed

or feminine style of leadership that assumes a more relational, local and shared understanding of leadership and organization', Sinclair (2007) critiques transformational approaches for remaining focused on the power and status of a single individual, assuming that charisma is a good thing, concluding:

‘these high-sounding aspirations [of transformational leadership] risk delivering greater enslavement to narrow corporate goals’ (Sinclair, 2007, p24).

The women chief executives in this research therefore appear to have received a message through their everyday experience that a leader in the NHS is meant to be a strong (arguably masculinised, although this risks too narrow an understanding of masculinity [Hearn, 2008]) individual, focused on delivery of targets, and unforgiving of failure, in contrast to the description of desired transformational leadership set out in national policy which asserts a more sophisticated and distributed approach to leadership (despite some critique suggesting this too is a heroic model of leadership relying on traditional concepts of power, status and influence). However, this begs a question as to how the women, as followers of their leaders, respond to their experience of leadership expectations, given what they recount of their dissonance in relation to prevailing values and culture.

This assertion of followers as subordinate to dominant leaders is explored by Collinson (2006) in a paper that concludes that the follower-leader relationship is more complex than a simple top-down power relationship, in that follower identities impact on those of leaders, as well as the other way round. Collinson draws on the work of post-structuralists such as Kondo (1990) in highlighting once again the multiple and shifting nature of self and selves, and concludes:

‘In sum, post-structuralist perspectives argue that the identities of followers and leaders are frequently a condition and consequence of one another. This raises an interesting possibility, rarely considered in the literature, that followers might also impact on leaders’ identities.’ (Collinson, 2006, p186)

This analysis emphasises what some of the women in this research demonstrate, that experience of a dominant management culture does not have to be disempowering, for they find ways of (in Collinson’s critical discourse terms) of resisting the culture, including via the construction and performing of certain selves as part of an emancipatory attempt to shift the balance of power within organisations (see below for a discussion of resistant and subversive behaviour). It also opens the possibility that chief executives (be they men or women) can play (within a social constructionist frame) a part in shaping and narrating the identity and approach of those at higher levels of the organisation, in turn opening up the possibility of some shift (or at least renewed sense-making [Weick, 1995]) in the organisational culture. Indeed, some of the women explained how they sought to protect their organisation from the worst excesses of management experienced from above, seeking to inculcate a more post-heroic (in Ford’s terms) and distributed approach to how they managed their own organisation. Whether the women were here providing their own sense-making interpretive accounts within a constructivist discourse of how they shape their selves in response to a particular culture, or were participating in an attempt to actively change that culture through acts of resistance and challenge, is impossible to say. What is clear is that the use of a primarily dialogical lens to view the women’s accounts sheds light on the complex, multiple and shifting selves they construct and reproduce as they talk about their experience as women chief executives.

For Ford, the dissonance expressed by women in relation to her discourse of macho-management is essentially gendered, for, along with others such as Fletcher (1999),

Hearn and Parkin (2001), and Sinclair (2007) she asserts that gender and identity are inextricably intertwined with discourses of leadership. In the conclusion to her paper on leadership discourse she notes:

‘Macho, individualistic and assertive behaviours continue to be valued over the more feminine qualities such as empathy, capacity for listening, relational skills and so on. Where the rhetoric of a more feminine set of practices is suggested, such as within postheroic discourse, these have yet to be translated into practice as can be witnessed by the target-driven, financially motivated performance measurements that continue to dominate current assessment and audit arrangements in UK local government organizations.’ (Ford, 2006, p96)

What is clear from the research reported in this thesis is that Ford’s work within local government is replicated in the experience of women chief executives in the NHS.

Individual managers hear the rhetoric of transformational, distributed and postheroic leadership, but what they experience is an ongoing management approach that appears more closely associated with a discourse (in Ford’s terms) of macho-management.

What is of interest here is how they choose to respond to this dissonance. As explored in the next section, this response can take the form of adaptation to a predominant leadership archetype, along with other forms of resistance and even subversion. The response made is however complex, and entails the construction and reproduction of multiple and shifting selves, selves that enable the women to ‘gender-switch’ and ‘double-voice’ as necessary.

6. Have I adapted to the predominant male archetype of leader by becoming ‘male’?

Researchers into gender and organisation have noted the tendency for women working in normatively masculine management cultures to try and downplay their gender identity and try and blend in as one of the boys (Ford, 2005) as an honorary

man (Collinson and Hearn, 1996) or as a female man (Marshall, 1995). Fletcher described what she found in a US research project as:

‘a masculine logic of effectiveness operating in organizations that is accepted as so natural and right that it may seem odd to call it masculine. The logic of effectiveness suppresses or “disappears” behaviour that is inconsistent with its basic premises.’ (Fletcher, 1999, p3)

In this study, chief executive G commented on the fact that she was able to be ‘like a male chief executive really in that the childcare was always there...’ and chief executive D asserted that ‘I don’t really think of myself as a woman at work, even if I am the only one there. I am almost asexual.’ These examples demonstrate that when it comes to how they perform their role in the workplace, these particular women leaders are, to some extent, choosing to portray themselves in a more masculine or asexual, rather than explicitly feminine manner. In other words, in Butler’s terms, they choose to perform their gender in a manner that they deem to be acceptable to the ‘gaze’ of the organisational audience that ultimately surveys and judges their performance.

As explored in chapter 3 (literature review) Collinson (2003) considered that making a career a project of self-management was a high risk strategy, one that was associated with a significant degree of insecurity. He advocated three strategies to be used in order to survive ‘the gaze’ of surveillance that was part and parcel of the workplace, and more exaggerated the more senior one became. These strategies were: conformism; dramaturgy; and resistance. In the research reported here, the women revealed examples of each of these three strategies. For example, the stories of career bore witness to a clear desire on the part of the women to conform to what is expected of an NHS senior management career, whether that be making the appropriate next

step in terms of job application, committing to work very long hours as is perceived to be 'required' by the NHS, or ensure that all performance targets set by the Department of Health are prioritised by the local organisation. Collinson suggested that conformism is sometimes achieved by the 'splitting of self', whereby an employee divides their identity between the work and 'real me' outside. In this research, chief executive A clearly demonstrated such an approach, setting out the following assertion of how she manages her role as a chief executive and assures herself of support:

'I have a clear view that work is work and home is home and the two things don't mix. I never take work home with me, no PC at home or stuff on the dining table. I deal with work by doing it at work. When I am away from work I don't socialise with people from work, I don't talk about work, and tend to have friends from other backgrounds. I don't mix the two.'

Whilst conformism was evident in all the women's accounts, either explicitly, or implicitly through their focus on pursuing career (or having pursued career to date) and working hard within the accepted NHS management culture, many of them revealed examples of how they elected to adopt what Collinson coins a 'dramaturgical self', acting out what they deem is required by those who monitor and assess them, and also how they choose to resist and express discontent about the workplace pressures to which they are subject. Collinson makes the following assertion about the use of a dramaturgical self as a form of workplace survival:

'In the workplace, dramaturgical selves are more likely to emerge where employees feel highly visible, threatened, defensive, subordinated and/or insecure. Various studies document the emergence of dramaturgical selves as an employee survival strategy within intensified monitoring.' (2003, p538)

The women in this research are in roles that are highly visible and public, and where, as we saw in chapter 2 (policy context) and chapter 6 (hearing the stories told by the women), they are experiencing intensified monitoring of financial and other

performance in an NHS under extensive political and public scrutiny. Some of them explicitly described their behaviour in terms of acting out a role in order to appear to conform to what they felt was expected of them by NHS policy and culture as expressed through the strategic health authority and Department of Health. Chief executive B explains her effort to perform her role as chief executive at all times:

‘You have to be a person with presence, dedication and self-motivated, and with self-belief, and not scared to roll your sleeves up and get stuck in. If you don’t love yourself, why should anyone else love you? You have to present yourself really nice all the time, look after yourself, and do all that. The chief exec has to really believe in what you are doing, for if you don’t as the chief exec, why the hell should anyone else? People need to respect you and follow you.’

And chief executive I talks about a conscious decision to look strong and composed in all her dealings with the SHA she accuses of being overbearing in its dealings with its chief executives:

‘It is very dangerous to pretend. But if your feelings are betrayed and you appear to be panicked or despairing, you cannot lead. So part of the job is about best face forward. At the SHA however, that is part of the role – however much they push and prod you, you never ever show you are the slightest bit afraid and I don’t feel any guilt about that, acting, and saying everything is fine and we are enjoying all the challenges.’

In this way, the women are demonstrating how they perform or enact their leadership, in this case in order to survive a performance management culture that is at times threatening and unsettling to the chief executives as individuals. This clearly draws on Goffman’s (1959) ideas about impression management in the workplace, and work by researchers such as Miller and Morgan (1993) and Collinson (1993) who examined the emergence of dramaturgical selves in situations where employees face intensified surveillance.

In relation to resistance, the women in this research revealed a range of strategies that in some cases had a clear sense of subversion to them. Chief executive C's 'coven' meetings over dinner with women peers, chief executive B's work with her local woman chief executive colleague to develop an integrated network approach to service development beyond a market approach, and chief executive G's chairing of the trust chief executives' network in a consensus manner, all demonstrate an explicit decision to do something that will resist the prevailing culture, and provide an alternative way of doing things. Collinson (2003) noted that some resistance strategies are 'frequently covert and subterranean' (op cit, p539) as is the case with chief executive C's 'coven' meetings, and chief executive B's network, in so far as chief executive B presents it as something she and her colleague have developed as a pair of women who are determined to prove that they can get on and do things differently from what appears to be the expected norm.

Collinson drew on Kondo (1990) in pointing out that strategies of resistance can be challenged in respect of themselves being 'caught in contradictions, simultaneously legitimizing as they challenge dominant organizational and gendered discourses' (Collinson, 2003, p540). In this research, we witness this ambiguity – chief executive I talks feistily of how she openly stands her ground with the SHA, yet then talks of the need to act a competent and composed self, of:

'lashing yourself to the bloody wheel and trying to stop it moving too many degrees off course. No sunshine and no horizon, so you can keep your vision to yourself. It is about plotting the course and staying steady.'

This points to the fundamental dilemma faced by all the women in this research – how can they utilise strategies of dramaturgical selves, resistance and conformism, and yet

craft selves that enable them to make overall meaning for themselves in the manner described by Crossley (2000)?

In apparently conforming to some assumed way of working that is expected by the wider organisation, acting out a role as chief executive in order to appear confident and in control, and engaging in covert acts of resistance to find support and develop alternative strategies, these women are attempting to survive and thrive as chief executives and as mothers, employees, partners and so forth in a context that appears to feel insecure, high-risk, and at times threatening. When asked to tell their stories, a dialogical approach to narrative analysis suggests that the women co-construct with the researcher multiple and shifting selves, the medium of language being used to interpret and make sense of their experience in relation to different and often conflicting roles and contexts.

In the other dilemmas discussed in this chapter, it was noted that the women who were mothers had pragmatically adopted childcare and family arrangements that enabled them to work 'as if a man', most had used male sponsors to further their career and thus help them to 'play the game' of career advancement, and despite some dissonance of personal and organisational values, the women realised the need to perform the role expected of them by their strategic health authority and the Department of Health. Arguably, the women had, in this assumption of 'working like a man', allowed gender to 'disappear' in Fletcher's (1999) terms, finding that adaptation to the prevailing cultural norms of the workplace was preferable to mounting what Myerson and Kolb (2000) called a fundamental 'change from the fourth frame'.

Throughout this exploration of the women's narratives therefore, there is a strong sense of adapting or conforming to a predominant model of NHS leadership, one that feels to be concordant with Ford's macho-management and professional career discourse, or what Gordon (1991) described as women becoming the 'prisoners of men's dreams'. This is despite protestations of a move to transformational leadership in the NHS (e.g. Bevan, 2005) that might be more concordant with Ford's postheroic discourse, albeit that transformational leadership itself is subject to criticism by Sinclair (2007) for continuing the tradition of a sole heroic leader.

Of particular note is the apparent need by the women to downplay or silence what Ford termed the social and family discourse, both in how they organise their working lives, and when narrating their career require prompting to reveal the presence of corporate husbands, children and wider 'hinterland'. This suggests that in order to survive as chief executives, when part of a gender minority in such roles, these women have chosen to adapt to the model of leader 'required' by the NHS (and hence 'disappear' gender), rather than challenge this hegemony by shaping a new leadership approach or calling for a fundamental change to the way in which such senior roles are constructed and operated. This is not to say that the women are not trying to bring their own experience and preferred approach to bear on how they manage their organisations and themselves, for they recount numerous examples of resistance in the face of the organisational culture in which they operate.

This raises a fundamental question as to how the women's stories should be interpreted, and in turn what implications the stories have in relation to insights into

chief executive roles and how they are (and might be) experienced. As set out in chapter 4, the theoretical lens through which the stories are viewed has an impact on what emerges from analysis of the data, and influences the interpretation drawn from that analysis. For example, it could be argued that the women in their accounts reflect the dominant health sector (functionalist) discourse in stating ‘how things are and have to be’ within a particular management and organisational approach.

Alternatively, their acts of resistance and challenge could be regarded (within a critical discourse) as taking part in a shifting of the predominant culture and power paradigm, making Chesterman et al’s ‘tipping point’ a reality as women assume the ‘critical mass’ of over a third of the chief executive population in the NHS.

Within the dialogical discourse adopted as the primary theoretical lens through which to view these stories, albeit supplemented by elements of critical and constructivist discourse, the accounts offer insights into how female senior leaders construct and reproduce their identity in a manner that is both paradoxical and playful, seemingly shifting back and forth, revealing both anxiety (after Ford et al, 2008) and a more sensuous or poetic sense of self (after Shotter, 2008). These multiple and shifting selves are co-constructed with the researcher, and thus draw upon a constructivist discourse that emphasises the importance of sense-making. The multiple and paradoxical nature of the selves constructed by the women is what lends the air of ‘trouble’ to the times they describe, and the ‘gendered’ perspective invokes a critical discourse of power relations in the workplace that form part of that very sense of trouble the women experience.

What is clear from this research is that the women make sense of their experience as chief executives by constructing multiple selves within the stories they recount, stories that are at once troubled and gendered. The prevailing culture of NHS leadership is a context that appears to bring forth both conformism and resistance and it appears that the women have chosen to adapt their working and family lives to accommodate the evident expectations of how a chief executive role should be performed. These requirements seem to represent a model of NHS leader that entails more than full-time working for a 'hero' or 'heroine' form of leader who is personally charged with leading the organisation, motivating the workforce, and 'winning the battle' in terms of meeting targets, balancing the books, and reassuring more senior levels of the hierarchy that good progress is being made.

A cadre of senior managers that works flexibly and relies on NHS provision of childcare in the workplace has not been found within this research, suggesting that actions by NHS policy makers to try and extend flexible working and childcare as an attempt to increase the proportion of women managers (offering equal opportunity in Myerson and Kolb's second frame) have not borne fruit. On the contrary, women in chief executive positions have chosen to 'gender switch' (Bruni and Gherardi, 2002) and become the primary breadwinner in the family, and hence we see the emergence of 'corporate husbands' who stay at home to look after the children, enabling women chief executives to arguably 'work like a man'.

This suggests that despite policy protestations to the contrary, the NHS continues to seek and favour a model of leadership that is in the heroic and 'great man' tradition (Borgatta et al, 1954), and the findings of this research suggest that women are trying

to adopt a 'great woman' approach in shaping their leadership roles (Peck, 2006), whereby they can adopt a style that is more 'transformational' (Alimo-Metcalf, 1998) and associated with 'servant leadership' (Greenleaf, 1977; Boje and Dennehey, 1999), albeit that they are still expected to be a strong individual leader who can 'deliver' the requirements of leadership (Sinclair, 2007).

Questions that remain

What was not said in the narratives?

These women have told their story of career, revealing dilemmas and anxiety related to the ascription of success, career sponsorship, motherhood, the impact of career on partners, dissonant personal and organisational values, and how far they might have adapted to a predominant male archetype of leader. In the analysis thus far, the focus has been on what the women said, as individuals and as a community of leaders, and on the different ways in which their stories might have been interpreted. It is however also instructive to reflect on what they did not say, and to speculate about how else they might have narrated their experience of being women leaders in the NHS.

In particular, the women made hardly any call for flexible working, part-time or job-share chief executive roles, targeted development for female managers, or other 'equal opportunities' type interventions of the sort witnessed in the 1990s through the Opportunity 2000 initiative, and advocated in earlier studies of women in NHS management (e.g Disken et al, 1987; Goss and Brown, 1991; IHSM Consultants, 1994). Implicitly, it once again appears that the women were accepting that NHS

chief executive posts have to be full-time and operated in the current paradigm of long-hours and solo 'great' man or woman.

Despite a number of the women in this sample having personally benefited from the activities of the NHS Women's Unit in the 1990s (a national attempt to 'fix the women'), they appeared, by not asserting any further need for this in relation to the next generation of women managers, to assume that the Women's Unit was an initiative needed at one particular point in time. Myerson and Kolb's (2000) analysis of the ways in which attempt to address gender inequity typically evolve would support this analysis of the NHS Women's Unit having been part of first and second frame change (fixing the women and creating equal opportunity). An alternative explanation for the women chief executives' failure to call for measures to expand the number of women in NHS senior management (and in a couple of cases to explicitly say that women should not be specifically supported in this) could be that these women were 'pulling up the ladder behind them' doing what Barres (2006) in a review of women in science called 'perversely believing that if other women are less successful, then one's own success seems even greater' (p134).

The other area where it could be considered surprising that the women did not say more is in relation to what they as individuals were doing to encourage and develop other young (and in particular women) managers within their organisation and the wider NHS. Chief executive G talked of her commitment to management development, mentoring, and the encouragement of women and minority ethnic managers, and chief executive I asserted how she sought to enable young women managers to learn about the political skills they would need to make progress in their

career. Apart from this however, there was scant mention of these women seeking to be the career sponsors or mentors who had clearly enabled this cohort of women to achieve the senior roles in which they were now working.

The absence of commentary about this issue may relate to how the questions were framed for the interviews, however, given that chief executive G found the space to focus on the issue in her interview suggests that for some reason, the women did not choose to portray themselves as career sponsors of other managers (of whichever gender) nor to set themselves out as a champion of women moving into management. This begs a question as to whether, with the demise of the NHS Women's Unit and a lesser policy focus on gender in health services management as noted in chapters 2 (policy context) and 3 (literature review), women managers themselves have shifted their own attention away from the issue as they have apparently 'gender-switched' and adapted to a predominant masculinised model of NHS leadership.

Related to these previous points about an absence of commentary by the women about equal opportunities and the development of women managers, it is interesting to reflect on the fact that some of the women actively denied the gendered nature of their experience as NHS chief executives when telling their story of career, asserting no need for 'special support', saying that 'women make their own choices about where they work', claiming to be 'asexual' at work, and to not having really thought of themselves as a woman manager particularly. This in itself appears to be paradoxical and potentially a further dilemma in the women's experience, for even some of the women who took this 'ungendered' (or, after Fletcher, 1999, disappeared gender)

stance talked of the issues they faced as women managers elsewhere in their interview.

It may be that the women, operating in a organisational culture in which gender seems to have disappeared in the face of a predominant macho-management discourse (after Ford, 2006), have chosen to conform, perform and occasionally resist, feeling constrained in relation to the type of self or selves they can present in their narrative of career. Some of the women commented in their interview, or in informal discussion after, that it had been a rare opportunity to talk about their career experience, to reflect on being a woman chief executive, and to do so in the context of their wider life experience. Thus it is possible that the women were unaccustomed to telling the story of themselves as a woman in NHS senior management, having an opportunity to 'do their identity work' in a reflective and safe space, and thus it could be considered unsurprising that it was a troubling and complicated business to construct and reproduce their different selves within the interview.

Similarly, whilst some of the women felt ready and able to talk about gendered issues in being a woman manager, others may have felt that this was too risky, even in a confidential research interview. Furthermore, for a few of the women, the striking theme of their narrative was more concerned with transcending class barriers related to their family background, over and above their specific experience of being a woman manager. In other words, for some of the women, being 'outside' the prevailing leadership discourse and approach was possibly more associated with class and family background than with gender (Sinclair and Wilson, 2002).

Can management be un-gendered?

This leads to a wider question about whether management can be ‘un-gendered’. Broadbridge and Hearn (2008) identified typical patterns in how management is gendered, including: gendered divisions of labour in management; gendered divisions of authority in management; gendered relations of organisational participants to domestic and related responsibilities; and the valuing of organisations and management themselves over work in private domains. These authors claimed that management was fundamentally gendered in relation to men’s continuing dominance of management posts in most organisations, persisting differentials in what women managers are paid in relation their male counterparts, and women being more likely to have experienced discrimination. They also point out that management continues to find women concentrated in certain spheres (as with community services, mental health and commissioning in the NHS) and not in others (as with large acute NHS trusts). Broadbridge and Hearn underlined the complexity of the gendering of management: ‘gendered processes and their interrelations are not monolithic, but often paradoxical and open to multiple interpretations’ (Broadbridge and Hearn, 2008, pS41).

This research appears to have at once confirmed the gendered nature of health services management, in relation to the lack of representation of women at chief executive level and their concentration in certain sectors that are ‘less popular’ and where they appear to be paid less than men. The complexity of such gendered processes emerges from the dilemmas revealed in the women’s narratives, with maternal guilt mixed with pride in ‘alternative’ family and childcare arrangements, ascription of success to both luck and competence, and dissatisfaction expressed with

policy focused on market forces within health care at the same time as gaining satisfaction from succeeding as a manager in that very context.

Can selves be crafted through storytelling?

The core question remaining to be answered as a result of this discussion of the dilemmas faced by NHS women chief executives is that of whether the women can create crafted selves within their accounts of their career, in the face of such a complex, gendered organisational environment where they find themselves adapting to a prevailing (and arguably masculinised) model of leadership. Central to the analytical framework of this research is the dialogical concept of multiply crafted selves (Kondo, 1990) as constructed and reproduced in encounters between an individual and others. The research has taken an explicitly poetic and dialogical social constructionist view, whereby giving someone the time and space to tell their story of career is in itself a medium through which they can construct and reproduce multiple selves that in turn enable them to make sense of their experience and craft selves into something that Crossley (2000) would assert lends ‘meaning to go on’.,

The women’s stories, and the dilemmas inherent to these accounts, reveal the extent to which they inhabit conflicted and complex roles. For many of the women, they are at once the mother of children who clamour their time and attention, and full-time career woman conforming to the NHS management long-hours and hero-leader culture. In the area of values, the chief executives revealed a strong public service ethic, yet sometimes appeared almost despairing at how this was being challenged by what they saw as government health policy focused on markets and competition. Survival in such conflicted roles was being sought through a range of strategies,

including: conformism to the expected culture and working patterns of the chief executive role; the acting out of composure, confidence and compliance in the face of challenge from the supervisory tier; and resistance in ways that were both overt (e.g. refusal to bow to demands from the strategic health authority) and covert (development of strong networks of like-minded women for support and/or a different approach to service planning).

In the social constructionist context of this research, this leads to a question about how the women were able to make overall sense (Weick, 1995) of themselves within the context of the story told of being a chief executive in the NHS in late 2006/early 2007. The assumption of people presenting multiple selves - for example, chief executive, mother, daughter, wife, boss, subordinate, peer – presents an analytical challenge in respect of how these women can therefore develop and hold onto a sense of some form of holistic and integrated self (if, in Crossley's terms, we assume such an integrated self is necessary or desired, which in a purely dialogical approach, it is not).

Thus the women present multiply crafted selves, a crafting that is specific to a particular co-constructed meeting with a researcher at a particular moment in time, and one that is contextualised by the NHS and its specific culture and predominant model of leadership. The crafted selves reveal something of the complex dilemmas experienced by women working in these roles, dilemmas that are as fundamentally gendered as the nature of health services management itself. In the spirit of the storytelling that enabled the revelation of multiply crafted selves in this research, this

discussion ends with an account by one of the women (chief executive D) of how she crafts (or in her terms, shapes) her selves that are a chief executive and a boss:

‘It is about being able to influence, make things happen and get things done. That is what I like about being a chief exec. And it is about freedom, being able to do things, I can shape things as a chief exec, it is my sandpit and I can make it what it is. I am my own boss, shaping things – it is not other people shaping it for you. Why would I not want all this freedom and the ability to do what I want to do. I am my own boss. That is the essence of it.’

Chapter summary

In this chapter, an exploration has been made of the overall findings from the research, including those based on analysis of two national surveys of NHS chief executives carried out in 2003 and 2006, and others arising from narrative analysis of ten interviews carried out with women chief executives in late 2006. The six dilemmas revealed within the process of narrative analysis have been explored within the context of relevant literature, with a focus on determining what this means for future thinking and research in relation to gender, organisation and leadership. Core questions that remain following this discussion include: what was not spoken about within the narratives; the extent to which management could ever be ungendered; and whether selves can be crafted with a narrative process. In the next and final chapter, the findings from this research are explored in relation to the original contribution deemed to have been made by the thesis.

CHAPTER 8

CONCLUSIONS

Introduction

This final chapter draws together the key themes and findings from the research and sets out the original contribution to knowledge made by the thesis. The original contribution is asserted to include the following: a mapping of the chief executive population of the NHS in England and revelation of persisting lack of representation of women, ethnic minorities, and disabled people at chief executive level; a contribution to the body of literature and knowledge on conceptualising women in senior roles, in particular in relation to the ‘anxieties’ they experience; an important addition to the social constructionist methodological literature in the field of leadership; and a set of policy implications for the NHS in relation to its model and practice of leadership. Furthermore, consideration is given the questions raised in this thesis that would be worthy of further research, and a reflection is made on the overall process of having conducted this PhD study..

Mapping the chief executive population of the NHS in England

This research set out to map the demography of the chief executive population of the NHS in England, and to identify key areas of similarity and difference between the populations of NHS trust and PCT chief executives. To do this, two national surveys of NHS trust and PCT chief executives were carried out in 2003 and 2006. Analysis of the data gathered in the two surveys revealed that the NHS chief executive population continues to be predominantly white, male, not to consider itself to be disabled, and to work full-time. The only area where there appeared to have been change in the make-up of the chief executive population since the Creative Career

Paths mapping study of the mid-1990s appeared to be in relation to gender, where there had been an increase in the overall percentage of women chief executives.

Closer examination of the data revealed that much of this change in relation to gender was caused by equal representation of men and women in the population of PCT (purchasing and primary care organisation) chief executives, with little change having taken place within the gender composition of hospital trusts. PCT chief executives tended to have lower salaries than their NHS trust counterparts, suggesting that these latter organisations continued to be perceived to be the 'toughest' NHS organisations as had been noted in earlier studies. Whereas in 2003, PCT chief executives were more likely to be younger than those in NHS trusts, this difference was not present in 2006, suggesting a maturing of the PCT chief executive population as this form of organisation gained some longevity within the NHS system.

Senior NHS management was also revealed to be an insecure and tumultuous profession, with over two thirds of chief executives having been in post for less than three years. This was important context to the analysis of women chief executives' narratives of career, where strategies for addressing insecurity featured as a significant theme in relation to how the women were able to make sense of their work and wider life experiences.

The mapping of the chief executive population was carried out first and foremost in order to try and better understand this cohort of managers, and to provide a basis for more in-depth examination of chief executives' role and experiences in the second stage of the research. The surveys were however more than just an exploratory stage

of a single research project. They provide an important insight into the demography of NHS senior management, a cadre of staff that has been subject to relatively little analysis apart from studies of new general managers in the 1980s, and of women managers (or rather a lack of women managers) in the 1990s. Thus the setting out of detailed analysis of the composition of the NHS chief executive population in 2003 and 2006, drawing on national surveys with high response rates, is in itself a distinctive contribution to the literature on health services management in the UK.

The analysis highlights a set of specific concerns related to this population, including:

- the continuing gender imbalance of the NHS chief executive population overall;
- the lack of women chief executives in acute (and especially in large acute) trusts;
- the different nature of the PCT chief executive population that has an almost 50:50 gender split;
- the overwhelmingly white nature of the chief executive population, representing a failure of the NHS to have a chief executive cohort that is representative of the wider population in relation to ethnicity;
- the lack of chief executives considering themselves to be disabled;
- the almost total lack of part-time, job-share or flexible working practices within the chief executive population; and

- the high level of turnover NHS chief executives, with the average length of time in post being approximately three years.

In the course of this research, a decision was taken to focus explicitly on the role and experience of women chief executives in the second and more in-depth stage of fieldwork and analysis. This was not in any way to deflect from the critical importance of the whole set of issues highlighted above, but rather a reflection of the personal interests of the researcher, and a desire to focus on one key aspect of the chief executive population that defined ‘difference’ between NHS trusts and PCTs. Thus the research went on to collect and then analyse the stories of a sample of women chief executives, to delve deeper into the experiences of this cohort of managers and to try and understand how they both ‘told their story of career’ and in so doing to reflect on how they chose to construct and reproduce selves, and in so doing revealed some of the dilemmas and anxiety associated with doing this identity work.

A contribution to the body of literature and knowledge on conceptualising women in senior roles, in particular in relation to the ‘anxieties’ they experience

The stories of ten women chief executives set out in this research are stories that are rarely heard within the NHS in England. Following the Creative Career Paths research carried out for the NHS Executive in the mid-1990s, apparently little empirical work has been undertaken with a view to eliciting the experiences of women chief executives, and certainly not work that has been informed by the significant emerging theoretical material on storytelling, self and career.

These women represent a group who, as noted above, continue to represent a minority group within the NHS chief executive population, and markedly so within that of NHS trusts. Arguably, gender is regarded within NHS policy as an issue that was 'dealt with' in the 1990s through the activities of the NHS Women's Unit and Opportunity 2000, which resulted in some increase in the number of women chief executives, finance directors, medical directors and chairs, albeit not as great as intended (Corby, 1995). This sense of gender being 'yesterday's issue' (or disappeared, after Fletcher, 1999) might have been one reason why the women in this research chose not to call for further equal opportunities action to increase the number of women chief executives, nor to focus in any significant way on how to encourage a further generation of women to reach chief executive level.

It is the analysis of the women's stories, and the use of a pluralistic and social constructionist theoretical approach to underpin this, that represents a particularly unique contribution to the literature that seeks to conceptualise women in senior roles. The research drew particularly upon the work of Dorinne Kondo and Jackie Ford in assuming a dialogical social constructionist approach, regarding the women's stories as reproducing multiple and shifting selves as they explored and sought to make sense of their different roles in the many contexts within which they live and work. This analysis also drew on critical management studies in regarding the women's accounts as gendered, and reflecting something of the gendered nature of NHS organisation and culture. The resulting analysis of the dilemmas experienced by women in senior roles echoes the work of Ford et al (2008) who speak of the anxieties inherent in doing identity work in such senior positions.

The uniqueness of the research reported here perhaps lies in the exploration of the doing of such identity work within the context of the NHS, and organisation that, as noted above, appears from a policy perspective to regard the issue of gender as having been ‘dealt with’. Narrative analysis of the women’s stories reveals some of the ‘anxieties’ of senior women chief executives in 21st century public services, a powerful empirical contribution that goes beyond what was previously available, at least in relation to the NHS, and points to policy implications that are explored further below.

Thus the opportunity to tell the story of career presented each of the ten women chief executives with an opportunity to do their identity work, to narrate and re-story the self (Holstein and Gubrium, 2000) in a way that seemed to each of them to be appropriate to the confidential research interview with a particular researcher at a specific point in time. The stories not only set out information about each woman’s career, family life, and conceptualisation of her role, but also revealed something of how they made sense of their role as chief executive, mother, employee, partner, friend, and so on. A number of the women commented to the researcher about the interview being a rare opportunity and space to do such reflection and to consider the interaction of different parts of their life. In this way, they appeared to be acknowledging the value of the storytelling experience as a space for identity work and the ‘crafting of selves’.

When the ten stories were analysed as a ‘community of stories’ (Chase, 1995), they revealed six dilemmas which seemed to weave in and out of the narratives, reflecting

the inherent complexity of the women's gendered experiences of being senior leaders in the NHS, and pointing to some of the particular points of tension in their careers and wider family lives. Of particular original note within these dilemmas is the role of the 'corporate husband' or partner who supports senior women leaders in the NHS, the importance of male sponsors and mentors to the women's career progress, the dissonance of personal and organisational values, and a strong sense that the women have chosen to adapt to a prevailing 'macho-management' culture and model of leadership in the NHS, given the persistence and strength of such a culture as revealed in these gendered stories of leadership in difficult times.

An addition to the methodological literature in the field of leadership

As well as representing a contribution to literature conceptualising women in senior roles, this research is also important in relation to its specific methodological approach, and most specifically in how the analysis of the women's narratives was carried out. As explored in chapter 4 (methodology), alternative theoretical approaches to the analysis of the narratives would have been likely to elicit different perspectives and conclusions about the experience of senior women in the NHS.

To give senior managers the time and space to 'tell their story of career' is in itself relatively rare, and to then approach those stories as what Shotter (2008, p501) calls places in which there is 'continuous creation of novelty' and where multiple selves are co-constructed by researcher and respondent, is of itself novel, at least in the context of NHS management research. This dialogical approach, when combined with a critical discourse that examines the accounts through a gendered as well as social constructionist lens, demonstrated how narrative analysis of this nature can

bring forth insights into people's reported experience that 'tell a different story' about what it is to be a senior woman in the NHS.

Ford (2006) called for more studies to be carried out that explored the stories and experience of leaders in a pluralistic manner that enabled multiple and contradictory selves to be reproduced and (in Kondo's terms) crafted. This research has sought to respond to that challenge, and is intended to extend the emerging body of literature on leadership in the NHS, in particular in relation to the undertaking of identity work within storytelling as a method of research within a context where positivist health service research in the functionalist discourse is by far the predominant and typically preferred approach.

Policy implications for the NHS about its model and practice of leadership

The results of the two surveys of the NHS chief executive population raise a key question in relation to why the NHS, as the largest employer in the UK, has not been able to develop a more diverse chief executive population that can properly reflect the composition of the wider population and NHS workforce. Despite policy attention such as that given to women in the 1990s, and more latterly to people from black and minority ethnic backgrounds through the Race Equality Scheme (Department of Health, 2005b) in the 2000s, there appears to have been little progress in relation to shifting the profile of the 'typical NHS chief executive'. This raises an important question for policy makers about whether the lack of diversity within the NHS chief executive population, together with the relative silence in relation to gender within health policy in recent years, means that there is a need to consider further positive action to enable specific population groups to become NHS chief executives.

A further policy question raised by this study in relation to the composition of the NHS chief executive population is how far specific initiatives such as the establishment of the NHS Women's Unit and the introduction of primary care group and trust chief officer posts in 1999 enabled something of a 'cohort effect', bringing a particular group of women into NHS senior management at a point in time, a group that has subsequently been able to move into chief executive posts in statutory NHS bodies. The research reported here can only surmise in relation to such a potential effect, but a further repetition of the study could explore this issue, tracking individuals' progress in their chief executive careers (this would be possible given that the two earlier surveys were coded and respondents are known to the researcher).

Furthermore, the mapping of the chief executive population could be used as a basis for tracking the progress of other cohorts such as black and minority ethnic managers, seeking to identify any cohort effects related to specific initiatives such as development programmes for managers from black and minority ethnic communities. Given the role of primary care groups in apparently enabling a group of women managers to assume chief executive officer, and latter statutory chief executive posts in the NHS, it will also be of interest to track how far the policy push to develop social enterprise organisations (Department of Health, 2008) might also lead to the emergence of an alternative route into NHS senior management for women, or for others traditionally relatively absent from that population.

Data collected in the 2006 survey of NHS chief executives reported in this thesis raise a potential concern about NHS foundation trusts appearing to have a predominantly

male chief executive population. This may be on account of initial applicants for foundation status coming from larger acute trusts who, as identified in this study, are more likely to have a male chief executive. However, it would be interesting to track the demography of foundation trust chief executives to explore whether or not this particular organisational and governance structure has had any impact on the type of people chosen to lead these bodies. Given the apparent shift towards the PCT chief executive population being at least 50:50 male:female, analysis of the foundation trust chief executive population as it develops will be of interest, especially in relation to whether or not we are witnessing the gendered development of two parallel groupings of NHS chief executives, as predicted by Goss and Brown (1991) who suggested that purchasing organisations would attract women to a greater degree than provider trusts.

The analysis within this study of the experiences of women chief executives led to a conclusion that the women appeared to have chosen to adapt to the prevailing model of leadership in the NHS where the chief executive works more than full-time, is the sole 'great man or woman' leader, and needs the support of a 'corporate husband or wife' in order to enable family life that involves children. If this is the case to a wider extent within the NHS (and more extensive research with male and female chief executives would be required in order to confirm or deny this), a question is raised as to what sort of the leader the NHS actually wants.

The development of the NHS Leadership Qualities Framework in the early 2000s (NHS Leadership Centre, 2002), and associated activity by the NHS Modernisation Agency at that time focused on the importance of shifting NHS leadership away from what it chose to term a 'transactional' towards a more 'transformational' approach

(see chapter 3 literature review for a discussion of transactional and transformational leadership). As was noted in chapter 3, some authors (e.g. Rosener, 1990) have chosen to regard transactional leadership as ‘masculine’ and transformational approaches as being ‘feminine’. Others however (e.g. Alimo-Metcalf and Alban-Metcalf, 2005; Peck, 2006) suggest that there is a need for a more sophisticated approach that draws on both constructs to create a more inclusive model of leadership that is fit for modern organisations.

The findings of this PhD research challenge how far the NHS has actually been able to implement a model of leadership that is different to what was traditionally considered to be masculinised (e.g. Smith and Stewart, 1983; Goss and Brown, 1991; Alimo-Metcalf, 1991) and more in line with what appeared to be espoused by at least some elements of the Leadership Qualities Framework (LQF). It should be noted however that the LQF appeared to continue to focus on a ‘heroic’ model of an individual leader of charisma, and did not seem to challenge the idea that leadership is concentrated in a single ‘great man or woman’ who is expected to give their all to the organisation.

Likewise, the dilemmas expressed by the women bear witness to a model of leadership where parenting and family life is something to be kept separate from work, an activity for which there is no time within more than full-time chief executive roles, and hence women express guilt and regret about their ability to mother, and demonstrate how they have sought to resolve this through the negotiation of ‘corporate husband’ support. This raises a question for the NHS and for society in general as to what sort of parenting we want, and what models of leadership and

management might be supportive of the parenting approach we decide is needed for the future. The analysis in this research noted the relative silence of husbands and partners within the narratives of the women chief executives. A group that was even more silent was the children of the chief executives, and further research might explore their perceptions and experiences of having a parent who is a senior executive in the NHS or other large public sector organisations, exploring their narrative of what it is to live within a family where one parent is working in a more than full-time chief executive role.

Questions for further research

In addition to the questions referred to within challenges for policy makers identified above, a matter for further research that emerges from this study is that of exploring the narratives of the corporate husbands. Having heard the stories of these ten women chief executives, one's curiosity is raised about what the men would say in their own stories of work, home-making, child-rearing, and shaping of identity and self. In exploring the narratives of the women, we have an incomplete sense of the ways in which families with an executive director parent make sense of themselves at an individual and family level. Further research could usefully gather and analyse the stories of corporate husbands, and of the children in these families, and could shed further light on the nature of NHS leadership in the 21st century. In addition to gathering the stories of such men, it would also be interesting to use any further mapping survey of NHS chief executives to find out how far these 'corporate husband' (or indeed corporate wife) arrangements are common among NHS leadership, and hence to form a view as to whether such men form part of a social movement related to parenting in the 21st century, or whether they are the latest

manifestation of traditional wives of corporate men, required to subjugate their own career ambitions in order to support the breadwinner role.

The dilemma about the predominant model of leadership in the NHS, and the extent to which the women have adapted to that by becoming 'male' points to a need for research within the NHS that explores in more details the nature of this 'predominant model' and the ways in which it is experienced by managers, clinicians, and other staff. This could be examined in relation to the impact on individuals, teams, organisations and the overall NHS, including the way in which the nature and experience of leadership affects perceptions of organisational culture. Whilst in the research reported in this thesis the model of leadership has been considered through a critical lens that regards the NHS as gendered and hence as acting in a manner that might be considered oppressive to women, the nature of NHS leadership could similarly be examined through a critical lens that explored its impact in relation to race, sexuality, disability and other dimensions of 'difference' that individuals bring to their experience and storying of organisational life. Furthermore, the impact on specific professional groups (such as nurses, doctors, clerical staff) could be explored, enabling consideration of how far the experience of chief executives in relation to model of leadership is distinctive, or whether it does in fact demonstrate something more far-reaching about NHS organisation and culture.

When shaping the second stage of this research, a decision was taken to focus explicitly on the experience of women chief executives. This does however raise a fundamental question about further research that could explore the stories of a matched cohort of men and women chief executives, in order to explore how far the

experiences of one gender are in fact distinctive or not. It was noted in the analysis of the women's narratives that the dilemma about personal and organisational values appeared, based on other research (e.g. Blackler, 2006) to be something that was common to male and female NHS chief executives, and not specifically gendered. Similarly, it would be interesting to explore the dilemmas related to mothering (fathering), corporate husbands (wives) from the perspective of male chief executives, as well as exploring the specific ways in which they might tell their own story of career and self, and analysing the gendered nature of their identity work.

When planning stage two of this research study, consideration was briefly given to collecting stories of women chief executives who had left the NHS, as well as the stories of those currently in post. Study of former chief executives formed part of the Creative Career Paths study in the 1990s, and research into the experiences and career paths of NHS management trainees in the 1980s likewise focused on those who had left the NHS as well as those who had remained. In both these cases, the decision to explore the experiences of former NHS managers was taken on the basis that the research was interested in what had happened to women chief executives, borne of a concern about the rate of attrition of women from NHS management. Given the picture painted in this current study of women as a persisting minority within NHS chief executive ranks, research into the stories of women who have left such roles would add a further dimension to consideration of the prevailing model of leadership, its effect on personal and family life, and could give insight into ways in which women might be encouraged and supported in remaining in NHS senior management in the future.

Reflecting on the process of undertaking this research

Having considered the questions revealed by this research that would be worthy of further investigation, in this section a reflection is made on the methods that were used in the study, with a particular focus on how the approach could be further developed in the future.

The survey questionnaire of NHS chief executives in England brought forth a high response rate and a wealth of data for analysis. This enabled significant findings to be reported concerning the composition of the chief executive population, and the repetition of the survey with a further (not quite as) high response rate enabled confident comparisons to be made over the three-year period. Inevitably, within the scope of this particular study, more analyses could have been made of the data from the surveys than was necessary for this research. For example, more in-depth exploration of the significance of professional (clinical or managerial) background, organisational size, type of organisation, staff employed and overall budget could be carried out, seeking to categorise organisations and their chief executives, and exploring the differences between such groups.

The survey questionnaire has the potential to become longitudinal beyond 2003 and 2006, for as relatively little mapping of the NHS chief executive population appears to have taken place over the past decade, this study now forms a basis from which longer term tracking and analysis could be carried out. Given that respondents to the survey were coded, there is potential to track the careers of individual chief executives over time and within cohorts, exploring who stays and who goes, rates of turnover in

different sectors, the influence of career and educational background, patterns of salary progression, and so forth. Furthermore, as noted earlier in this chapter, the survey could be used to track what happens to the emerging cohorts of foundation trust as opposed to PCT chief executives.

The use of storytelling and narrative analysis as a means of exploring how individual chief executives perform and portray their identity and self is an approach that, as noted earlier, could be employed with male chief executives, corporate husbands, and children of chief executives. Creating space for people to talk about their career and wider experience appeared to be a positive and therapeutic experience for the women concerned, as witnessed by the high rate of consent to be interviewed, lack of cancellation of interview arrangements, and comments made to the interviewer during informal discussion following each meeting. It would indeed be interesting to return to the same women after a period of time and to once again ask them to tell their story of career and self, using the original story as a starting point, given that the women will all be receiving a copy of a summary of this research thesis, and an opportunity to read the whole study. In this way, there could be further chapters of their story, a 'what happened next' together with reflection on previous hopes and intentions in the context of how events actually unfolded.

The use of in-depth interviews to hear the stories of career as told by women chief executives has enabled the collection and narrative analysis within a dialogical perspective of data that would have been hard to gather by other means. A number of the chief executives commented that they had shared personal experiences and reflections that they had rarely talked about with others outside of their closest circles,

clearly trusting the confidential research setting as a place in which they could ‘do their identity work’ with a sense of safety. The women appeared to regard the interviews as a chance to stand aside from the usual hustle and bustle of being a chief executive, to reflect on their experience and what had brought them to the current point in time. There was a sense of capturing a snapshot of a particular stage in their career and personal journey (freezing the dance, in Kondo’s terms), lending a privileged insight into a private and apparently anxious and paradoxical world of a senior executive in an organisation characterised by its unforgiving, long-hours and normatively ‘masculine’ culture at such senior levels.

This research was, as noted in chapter 1 (introduction) and chapter 4 (methodology) a journey, personally and methodologically, with my own reflexivity as a researcher forming a core part of how the research took shape, and in particular informing the co-construction of the women’s selves as told in stories and subsequently subjected to narrative analysis within a social constructionist frame. Therefore, at the conclusion of the research, it feels right to return to where the study started, with the process of me seeking to research what I arguably chose not to become – a female chief executive in the NHS.

The end is where we start from...

This research started out as an exploration into the demography of NHS chief executives, seeking to find out how far PCT chief executives were similar to or different from their counterparts in NHS trusts. It has made a distinctive contribution to research literature by mapping the NHS chief executive population and revealing its gendered nature; eliciting stories of career from women leaders; exploring these

stories in relation to the continuous identity work done by the women; examining therefore the ‘stories of selves under construction and reproduction’ as revealing particular dilemmas and anxieties; determining the areas in which these stories reveal themselves as gendered; and identifying further work to be done in relation to examining in a nuanced and poetic way the gendered nature of identity work within leadership.

Throughout this process, the research has also been a personal journey of reflexive study. From the initial curiosity about primary care organisation chief executives, through the decision to focus on examining the experiences of women chief executives, to studying dilemmas faced by working mothers and their corporate husbands, this has been both an academic and a personal exploration of career and self. The exploration has been of the careers and selves of ten women chief executives who are part of a minority within the wider population of NHS chief executives, and also an exploration by a former NHS manager of the experiences of women occupying jobs that arguably I might have inhabited, had I not chosen, in the 1990s, to leave the NHS and focus on research and analysis of health management, rather than on being part of the doing of this profession.

The research has revealed that whilst I did not become an NHS chief executive, in some ways, elements of my experience as a woman who pursues a career are common to those of the women in this study. I have tussled and continue to tussle with the guilt of being an often absent mother when at academic conferences and otherwise working overseas for extended periods. My husband and I have negotiated an arrangement where I am the main breadwinner and he works part-time whilst

assuming the primary childcaring and home-making responsibilities for the family – I have, in effect, a corporate husband.

Where perhaps my experience differs from the women is in respect of their dilemma about personal and organisational values. I recall well being deeply unhappy with pressures to achieve waiting list targets in the 1990s at almost any cost, and how this was just one factor in my decision to move away from NHS management. Academia offers me a more enquiring environment where it is legitimate to ask awkward questions, bring elephants into the room, and work with such dilemmas through my writing, research and teaching. In relation to the dilemma of career sponsorship, I realise now how often I have cited my NHS management training scheme (male) mentor and my various bosses (until recently all male) as key figures in enabling and supporting my development and career progression. I now wonder why that is, when I can also point to the woman who chaired by NHS management training scheme interview panel, my ‘second mentor’ appointed to me when a trainee in order that ‘I could have a female role model’, and my two (female) executive coaches as having also had a profound effect on the direction of my career and wider personal journey.

This research has formed a vital part of my academic and personal life over the past few years, and in particular the three years when most of the analysis and writing has taken place. It has offered me significant new insights into the nature of self and selves, the ways in which self and identity are performed and created, and most of all, just how far such identity work is profoundly gendered in its nature. Thinking back to the rather tortured time of my university finals, when my security was shaken by my father’s dying, and my faith was fundamentally challenged by both personal

experience and academic study, I am now struck just how the twin concerns of that time of an existentialist self, and a feminist narrative, have found themselves revisited and reunited in this journey and story of research.

REFERENCES

- Abel-Smith B (1964) *The Hospitals 1800-1948*. London, Heinemann
- Acker J (1990) Hierarchies, jobs, bodies: a theory of gendered organizations, *Gender and Society*, vol 4 no.2, pp139-158
- Acker J (1992) From sex roles to gendered institutions, *Contemporary Sociology* vol 21, no.5, 565-569
- Alban-Metcalf B (1989) What motivates managers: an investigation by gender and sector of employment. *Public Administration* vol.67 pp95-108
- Alimo-Metcalf B (1991) What a waste: women in the NHS. *Women in Management Review*, 6 (5) pp17-24
- Alimo-Metcalf B (1994) Gender bias in the selection and assessment of women in management. In *Women in Management: current research issues* by Davidson M and Burke R [eds]. London, Paul Chapman Publishing
- Alimo-Metcalf B (1995) An investigation of female and male constructs of leadership and empowerment. *Women in Management Review*, vol 10 no.2 pp3-8
- Alimo-Metcalf B (1998) (1998) *Effective Leadership*. London, Local Government Management Board
- Alimo-Metcalf and Alban-Metcalf (2005) Leadership: time for a new direction? *Leadership*, vol 1 no.1 pp51-71
- Allsop J and May A (1986) *The Emperor's New Clothes*. Family Practitioner Committees in the 1980s. London, King's Fund
- Audit Commission (1999) *PCGs: An Early Review of Primary Care Groups in England*. London, Audit Commission
- Auster D (1984) Mentors and Proteges: Power-Dependent Dyads. *Sociological Inquiry*, vol 54 no.2 pp12-153
- Baggott R (2004) *Health and Health Care in Britain*, third edition. Basingstoke, Palgrave Mcmillan
- Bakhtin M (1984) *Problems in Dostoevsky's Poetics*. Minneapolis, Minnesota: University of Minnesota Press
- Barres BA (2006) Does gender matter? *Nature*, vol 442 pp133-136
- Bass B (1985) *Leadership and Performance Beyond Expectations*. New York, Free Press.

- Beckett S (1959) *Krapp's Last Tape*. London, Faber and Faber
- Berwick D (2008) A transatlantic review of the NHS at 60. *British Medical Journal* vol 337 pp210-214
- Bevan H (2005) On reform from within. *Health Service Journal*, 1 September 005, p19
- Billing Y and Alvesson M (2000) Questioning the notion of feminine leadership: a critical perspective on the gender labelling of leadership. *Gender, Work and Organization*, vol 7 no.3 pp144-157
- Blackler F (2006) Chief executives and the modernization of the English National Health Service. *Leadership*, vol 2 no.1 pp5-30
- Boje D and Dennehey R (1999) *Managing in a post-modern world*. Dubuque Indiana, Kendall-Hunt
- Borgatta EF, Couch AS and Bales RF (1954) Some findings relevant to the great man theory of leadership. *American Sociological Review*, vol 19 pp755-759
- Boudens CJ (2005) The story of work: a narrative analysis of workplace emotion, *Organization Studies*, vol 26, no.9, pp1285-1306
- Boyce ME (1996) The organizational story and storytelling: a critical review, *Journal of Organizational Change Management*, vol 9 no.5, pp5-26
- Britten N (1995) Qualitative interviews in medical research, *British Medical Journal* vol 311, pp251-253
- Broadbridge A and Hearn J (2008) *Gender and Management: New Directions in Research and Continuing Patterns in Practice*, *British Journal of Management*, vol 19 , S38-S49
- Bruni A and Gherardi S (2002) Omega's Story: The heterogeneous engineering of a gendered professional self. Chapter 10 in Dent M and Whitehead S [eds] *Managing Professional Identities: Knowledge, Performativity and the "New" Professional*, pp174-198. London, Routledge
- Burns J (1978) *Leadership*. New York, Harper and Row
- Burrell G and Morgan G (1979) *Sociological Paradigms and Organisational Analysis*. London, Heinemann
- Burt RS (1992) *Structural holes: the social structure of competition*. Cambridge MA, Harvard University Press
- Bushardt S, Fretwell C and Holdnak B (1991) the mentor/protégé relationship: a biological perspective. *Human Relations*, vol 44 no.6 pp619-639

Butler J (1988) Performative acts and gender constitution: an essay in phenomenology and feminist theory, *Theatre Journal* vol 40 no.4, 519-531

Butler J (1990) *Gender trouble: feminism and the subversion of identity*. London and New York, Routledge

Caines E and Hammond V (1996) *Creative career paths in the NHS: the agenda for action*. London, NHS Women's Unit, NHS Executive

Calas M and Smircich L (1993) Dangerous liaisons: the 'feminine in management' meets 'globalisation', *Business Horizons*, March-April, pp71-81

Calas M and Smircich L (2006) From 'The Woman's Point of View' Ten Years Later: Towards a Feminist Organization Studies, chapter 1.8 in *The Sage Handbook of Organization Studies*, Clegg S, Hardy C, Lawrence T and Nord W [eds]. London, Sage

Caulkin S (1998) Crisis management all day, every day. *Management Today*, April pp46-51

Chase S (1995) *Ambiguous Empowerment: The Work Narratives of Women School Superintendents*. Amherst, University of Massachusetts Press

Chenevert D and Tremblay M (2002) Managerial career success in Canadian organizations: is gender a determinant? *International Journal of Human Resource Management*, vol 13 no.6, pp920-941

Chesterman C, Ross-Smith A and Peters M (2000) The Gendered Impact on Organisations of a Critical Mass of Women in Senior Management. *Policy and Society*, vol 24, no.4, pp69-91

Collinson D (1992) *Managing the shopfloor: subjectivity, masculinity and workplace culture*. Berlin, De Gruyter

Collinson D (1993) Introducing on-line processing: conflicting human resource policies in insurance. In Clark J [ed] *Human Resource Management and Technical Change*, pp155-174. London, Sage

Collinson D (2003) Identities and insecurities: selves at work, *Organization*, vol 10, no.3, pp 527-547

Collinson D (2006) Rethinking followership: a post-structural analysis of follower identities. *The Leadership Quarterly*, vol 17 pp179-189

Collinson D and Hearn J (1994) Naming men as men: implications for work, organization and management, *Gender Work and Organization* vol 1, no.1 p2

Collinson D and Hearn J [eds] (1996) It's only Dick: the sexual harassment of women managers in insurance sales, *Work Employment and Society* vol 1 no.10, 29-56

- Cm 249 (1987) Promoting Better Health. London, HMSO
- Cm 555 (1989) Working for Patients. London, HMSO
- Cmnd 7615 (1979) Report of the Royal Commission on the NHS (The Merrison Commission) London, HMSO
- Cooper C (1996) Hot under the collar. The Times Higher Education Supplement, June 21, 1996
- Corby S (1995) Opportunity 2000 in the National Health Service: a missed opportunity for women. Employee Relations, vol 17 no.2, pp23-37
- Cornejo G, Eveline J and Caspersz D (2008) Women in the legal profession: the impact of male networks and work-family balance on the career advancement of women lawyers to the partnership in private law firms. Paper given at the Engendering Leadership Conference, University of Western Australia, Perth, 21-24 July 2008
- Crossley ML (2000) Narrative psychology, trauma and the study of self/identity. Theory and Psychology, vol 10, pp527-546
- Davies C (1995) Gender and the professional predicament in nursing. Philadelphia, Open University Press
- Davies and Rosser (1986) Processes of discrimination. A report of a study of women working in the NHS. London, HMSO
- Dawson S, Winstanley D, Mole V and Sherval J (1995) Managing in the NHS: a study of senior executives. London, HMSO
- Day P and Klein R (1983) The mobilisation of consent versus the management of conflict: decoding the Griffiths Report, British Medical Journal vol 287 pp1813-1816
- Day P and Klein R (2005) Governance of foundation trusts: dilemmas of diversity. London, the Nuffield Trust
- Deaux K and Emswiller T (1974) Explanations of successful performance on sex-linked tasks: what is skill for the male is luck for the female. Journal of Personality and Social Psychology, vol 29 pp80-85
- De Beauvoir S (1949) Le Deuxieme Sexe. Paris, Gallimard
- Denzin NK (1989) Interpretative Biography. Newbury Park California, Sage
- Department of Health (1997) The New NHS. Modern. Dependable. London, HMSO
- Department of Health (2000a) NHS Plan: A Plan for Investment, A Plan for Reform. London, The Stationery Office

- Department of Health (2000b) Improving Working Lives Standard. London, Department of Health
- Department of Health (2001a) Shifting the Balance of Power within the NHS: Securing Delivery. London, Department of Health
- Department of Health (2001b) Research governance framework for health and social care. London, Department of Health
- Department of Health (2005a) Commissioning a Patient-Led NHS. London, Department of Health
- Department of Health (2005b) Race Equality Scheme 2005-2008. London, Department of Health
- Department of Health (2007) Creating a gender equality scheme: a practical guide for the NHS. London, Department of Health and NHS Employers
- Department of Health (2008) NHS Next Stage review: our vision for primary and community care. London, Department of Health
- DeSantis L and Ugarizza DN (2000) The concept of theme as used in qualitative nursing research, *Western Journal of Nursing Research*, vol 22 no.3, pp351-372
- DHSS (1983) NHS Management Inquiry (The Griffiths Management Report). London, DHSS
- DHSS and Welsh Office (1979) Patients First. London, HMSO
- Diaz de Chumaceiro C (2004) Serendipity and Pseudoserendipity in Career Paths of Successful Women. *Journal of Creative Behavior*, vol 37 pp193-214
- Dickinson H, Peck E and Smith JA (2006) Leadership in organisational transition: what can we learn from research evidence? Birmingham and Warwick, Health Services Management Centre and NHS Institute for Innovation and Improvement
- Disch L (1999) Judith Butler and the Politics of the Performative, *Political Theory*, vol 27 no.4, pp545-559
- Dixen S, Dixon M and Halpern S (1987) The New UGMs – Analysis of Management at Unit Level. *The Health Service Journal*, 2 July 1987, vol. 97, no.5057, Centre 8 Supplement, pp1-8
- Dixon J (1998) The context, chapter 1 in *Learning from the NHS Internal Market, a review of the evidence*, edited by Le Grand J, Mays N and Mulligan J-A. London, King's Fund
- Dixon M and Shaw C (1986) Maximising management investment in the NHS. King's Fund project paper no.58. London, King Edward's Hospital Fund for London

- Dopson S, Gabby J, Smith P, Stewart R and Williams D (1987a) *Managing with doctors: working together?* NHS Training Authority
- Dopson S, Gabby J, Smith P, Stewart R and Williams D (1987b) *DGM and the Chairman: a productive relationship?* NHS Training Authority
- Dopson S, Gabby J, Smith P, Stewart R and Williams D (1987c) *DGMs and the relationship between districts and units.* NHS Training Authority
- Dopson S, Gabby J, Smith P, Stewart R and Williams D (1987d) *Learning to be a DGM.* NHS Training Authority
- Dopson S, Gabby J, Smith P, Stewart R and Williams D (1987e) *Role and Progress of DGMs: an overview.* NHS Training Authority
- Doucet A (2006) "It's almost like I have a job, but I don't get paid": fathers at home reconfiguring work, care and masculinity. *Fathering*, vol 2 no.3 pp277-303
- Dowling B and Glendinning C (2003) [eds] *The New Primary care – modern, dependable, successful?* Maidenhead, Open University Press
- Duggan L (1998) The theory wars, or, who's afraid of Judith Butler? *Journal of Women's History*, vol 10 no.1, pp9-19
- Edwards B (1993) *The National Health Service: A Manager's Tale 1946-1992.* London, Nuffield Provincial Hospitals Trust
- Eliot TS (1944) *The Four Quartets.* London, Faber and Faber
- Emden C (1998) *Conducting a narrative analysis,* *Collegian* vol 5 no.3, pp34-39
- Enthoven A (1985) *Reflections on the Management of the National Health Service.* London, Nuffield Provincial Hospital Trust
- Equal Opportunities Commission (1991) *Equality of Management: Women's Employment in the NHS.* London, EOC and HMSO
- Equal Opportunities Commission (2006) *Sex and Power: who runs Britain?* Manchester, Equal Opportunities Commission
- Equal Opportunities Commission (2007) *The Gender Agenda.* Manchester, Equal Opportunities Commission
- Ferlie E (2001) *Organisational studies, chapter 2 in Studying the organisation and delivery of health services by Fulop N, Allen P, Clarke A and Black N [eds], pp24-39.* London, Routledge
- Feyerabend P (2000) *Conquest of Abundance: A Tale of Abstraction Versus the Richness of Being.* Chicago, University of Chicago Press

- Figs K (1998) *Life after birth: what even your friends won't tell you about motherhood*. London, Viking
- Finlay L (2002) Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, vol 2 no.2, pp209-230
- Fletcher J (1999) *Disappearing acts: gender, power and relational practice at work*. Cambridge, MA: MIT Press
- Flood M and Pease B (2005) Undoing men's privilege and advancing gender equality in public sector institutions. *Policy and Society*, vol 24 no.4, pp119-138
- Fogarty M, Allen I and Walters P (1971) *Women in top jobs: four studies in achievement*. London, Allen and Unwin
- Foley DE (2002) Critical ethnography: the reflexive turn. *Qualitative Studies in Education*, vol 15 no.5, pp469-490
- Ford J (2005) Examining leadership through critical feminist readings, *Journal of Health Organization and Management* vol 19 no.3, 236-251
- Ford J (2006) Discourses of Leadership: Gender, Identity and Contradiction in a UK Public Sector Organization, *Leadership* vol 2 no.1, pp77-99
- Ford J, Harding N and Learmonth M (2008) *Leadership as Identity – Constructions and Deconstructions*. Basingstoke, palgrave Macmillan
- Foucault M (1977) *Discipline and Punish: the birth of the prison*. New York, Vintage
- Foucault M (1988) Technologies of the self, in Martin L, Guttman H, Hutton PH [eds] *Technologies of the Self*. London, Tavistock
- Fournier V and Keleman M (2001) The crafting of community, recoupling discourses of management and womanhood, *Gender Work and Organization* vol 8 no.3, 267-290
- Gallagher and Shear (1999) [eds] *Models of the Self*. Thorverton, UK, Imprint Academic
- Garey AI (1999) *Weaving work and motherhood*. Philadelphia, Temple University Press
- Garfinkel H (1967) *Studies in Ethnomethodology*. Englewood-Cliffs, New Jersey, Prentice-Hall
- Gaskill LR (1991) Women's career success: a factor analytic study of contributing factors. *Journal of Career Development*, vol 17 no.3 pp167-178
- Gatrell C (2007) Whose child is it anyway? The negotiation of parental entitlements within marriage. *The Sociological Review*, vol 55 no.2, pp352-372

- Gatrell C and Cooper C (2007) (No) cracks in the glass ceiling: women managers, stress and the barriers to success. In Bilimoria D and Piderit SK [eds] Handbook on Women in Business and Management. Cheltenham, Edward Elgar
- Gergen K (1991) *The Saturated Self: Dilemmas of Identity on Contemporary Life*. New York, Basic Books
- Gergen K (1994) *Realities and Relationships: Soundings in Social Constructionism*. Cambridge MA, Harvard University Press
- Gherardi S (1995) *Gender, Symbolism and Organizational Cultures*. London, Sage
- Giddens A (1991) *Modernity and Self-Identity*. Stanford, California, Stanford University Press
- Gioia D and Pitre E (1990) Multiparadigm perspectives on theory building. *Academy of Management Review*, vol 15, no.4, pp528-602
- Glover WC (1986) *Mentors and fathers: a study of male developmental relationships*. Unpublished doctoral dissertation. The Wright Institute, Berkeley
- Goffman E (1959) *The presentation of self in everyday life*. New York, Doubleday
- Gordon S (1991) *Prisoners of men's dreams: striking out for a new feminine future*. Boston, Little, Brown
- Goss S and Brown H (1991) *Equal Opportunities for Women in the NHS*. London, NHS Management Executive and Office for Public Management
- Grbich C (1999) *Qualitative research in health: an introduction*. London, Sage
- Greenleaf R (1977) *Servant Leadership*. New York, Paulist Press
- Grey C (1994) Career as a project of the self and labour process discipline, *Sociology* vol 28, no.2, pp479-497
- Grint K (2000) *The Arts of Leadership*. Oxford, Oxford University Press
- Guba E and Lincoln Y (1994) Competing paradigms in qualitative research. In Denzin N and Lincoln Y [eds] *Handbook of Qualitative Research* (pp105-177). Thousand Oaks California, Sage
- Gubrium JF and Holstein JA (2001) *Institutional Selves – Troubled Identities in a Postmodern World*. New York, Oxford University Press
- Hall (1996) Who needs identity? In Hall S and Du Gay P [eds] *Questions of Cultural Identity*. London, Sage
- Ham C (2000) *The Politics of NHS Reform 1988-97 – Metaphor or Reality?* London, King's Fund

- Ham CJ (2004) *Health Policy in Britain*, fifth edition. Palgrave
- Ham C (2008) Competition and integration in the English National Health Service. *British Medical Journal*, vol 336 pp805-7
- Hamblin R (1998) Trusts, chapter 7 in *Learning from the NHS Internal Market*, a review of the evidence, edited by Le Grand J, Mays N and Mulligan J-A. London, King's Fund
- Hammersley M (1992) *What's wrong with ethnography?* London, Routledge
- Hansen E (2006) *Successful qualitative health research: a practical introduction*. Buckingham, Open University Press
- Harding N (1989) Equal opportunities for women in the NHS: the prospects of success? *Public Administration* vol 67: 51-63
- Harrison S (1982) Consensus decision-making in the National Health Service: a review, *Journal of Management Studies*, vol 19 no.4 pp377-394
- Harrison S (1988) *Managing in the National Health Service: Shifting the Frontier?* London, Chapman and Hall
- Harrison S and Wood B (1999) Designing the health service organization in the UK, 1968-1998. From Blueprint to bright idea... *Public Administration*, vol 77, issue 4, pp751-768
- Hearn J (2008) Putting men and leadership into context. Paper given at Engendering Leadership Conference, University of Western Australia, Perth, 22 July 2008
- Hearn J and Parkin W (1983) Gender and organizations: a selective review and critique of a neglected area. *Organization Studies*, 4 (3) 219-242
- Hearn J and Parkin W (2001) *Gender, sexuality and violence in organizations*. London, Sage
- Henry W (1967) Executive personality. In *The Emergent American Society: Large-Scale Organizations*, by Warner WL and Unwalla DB [eds], pp241-275. New Haven, Yale University Press
- Hertz R (1997) [ed] *Reflexivity and Voice*. Thousand Oaks, California, Sage
- Hirschmann AO (1970) *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations and States*. Cambridge, MA: Harvard University Press
- Hobbs SJ (1982) *Male Mentor Relationships: a study of psychological development in early adulthood*. Unpublished dissertation, California School of Professional Psychology, Berkeley

Holmes J and Schnurr S (2006) 'Doing femininity at work': more than just relational practice. *Journal of Sociolinguistics*, vol 10 no.1, pp31-51

Holstein JA and Gubrium JF (2000) *The Self We Live By: narrative identity in a postmodern world*. Oxford, Oxford University Press

Honan E, Knobel M, Baker C and Davies B (2000) Producing Possible Hannahs: Theory and the Subject of Research. *Qualitative Inquiry*, vol 6, no.1, pp9-32

Honigsbaum F (1990) The evolution of the NHS, *British Medical Journal* vol 301, pp694-699

Hughes C (2002) *Women's contemporary lives: within and beyond the mirror*. London, Routledge

Hunter DJ (2001) The NHS Plan: a new direction for English public health? *Critical Public Health*, vol 11 no.1, pp75-81

Huntington J, McClenahan J and Webster J (1987) Report of a project to investigate the training and development needs of family practitioner committees. London, King's Fund College, and Bristol, NHS Training Authority

Hyvarinen M (1996) Explaining Problematic Experiences: the methods of narrative coherence. Paper presented at the fifth International Conference on Narrative, University of Kentucky, Lexington

IHSM Consultants (1994) *Creative Career Paths in the NHS Report 1: Top Managers*. London, IHSM Consultants

Income Data Services (1998) *Public Sector Labour Market Survey. Report 775*, London, IDS

Jenkins P (1987) *Mrs Thatcher's Revolution: The Ending of the Socialist Era*. London: Jonathan Cape

Kalboolian L (1998) The New Public Management: Challenging the Boundaries of the Management vs Administration Debate. *Public Administration Review*, vol 58 no.3 pp189-193

Kanter RM (1975) Women and the structure of organizations: explorations in theory and behaviour, *Sociological Inquiry* vol 45, no.2-3, p34

Kanter RM (1977) *Men and Women of the Corporation*. New York, Basic Books

Kanter RM (1993) Preface to the 1993 Edition. *Men and Women of the Corporation*, 1993 Edition. New York, Basic Books

Kettl D (1997) The global revolution in public management: driving themes, missing links. *Journal of Policy Analysis and Management*, vol 16 pp446-462

- Klein R (1995) Big Bang Health Care Reform: Does it Work? The case of Britain's 1991 National Health Service Reforms, *Milbank Quarterly*, vol. 73 no.3, pp299-337
- Kondo D (1990) *Crafting selves: power, gender and discourses of identity in a Japanese workplace*. Chicago, University of Chicago Press
- Korda M (1976) *Power in the office*. London, Weidenfeld and Nicolson
- Kuhn T (1970) *The Structure of Scientific Revolutions*. 2nd edition. Chicago, University of Chicago Press
- Law J (1994) *Organizing Modernity*. Oxford, Blackwell
- Learmonth M (2004) Making health services management research critical: a review and a suggestion. In Learmonth M and Harding N [eds], chapter 1, pp1-23
- Le Grand J and Bartlett W (1993) *Quasi-markets and Social Policy*. London, Macmillan
- Le Grand J, Mays N and Mulligan J-A (1998) *Learning from the NHS Internal Market, a review of the evidence*. London, King's Fund
- Lewis R, Smith JA and Harrison A (forthcoming) 'From quasi-market to market in the National Health Service in England: what does this mean for purchasing of health services?', *Journal of Health Services Research and Policy*
- Mabey C and Finch-Lees T (2008) *Management and Leadership Development*. London, Sage
- Maddock S (1999) *Challenging Women: gender, culture and organization*. London, Sage
- Marshall J (1995) *Women managers moving on: exploring career and life choices*. London, Routledge
- Martin JR and Rose D (2003) *Working with discourse: meaning beyond the clause*. Continuum International Publishing Group
- Martin PY and Collinson D (2002) 'Over the pond and across the water': developing the field of 'gendered organizations'. *Gender, Work and Organization*, vol 9 no.3, pp244-265
- Maynard A (1986) Performance incentives in general practice. In: Teeling-Smith G [ed], *Health Education and General Practice*. London, Office of Health Economics
- Mays N and Pope C (1995) Qualitative research: rigour and qualitative research. *British Medical Journal*, vol 311 pp109-112

Mays N, Wyke S, Malbon G and Goodwin N (2001) *The purchasing of health care by primary care organizations: an evaluation and guide to future policy*. Buckingham, Open University Press

Mead GH (1934) *Mind, Self and Society*. Chicago, University of Chicago Press

Mennerick L (1975) Organizational structuring of sex roles in a nonstereotyped industry, *Administrative Science Quarterly* vol 20, no.4, p570-586

Miller N and Morgan D (1993) Called to account: the CV as an autobiographical practice. *Sociology*, vol 27 no.1 pp133-143

Mills AJ (1991) Organization as gendered communication act, *Canadian Journal of Communication*, vol 16 pp381-398

Mishler EG (1986) *Research interviewing: context and narrative*. Cambridge, Harvard University Press

Moss Kanter R (1975) Women and the structure of organizations: explorations in theory and behaviour, *Sociological Inquiry*, vol 45 issue 2-3, p34-74

Myerson D and Fletcher J (2000) A modest manifesto for shattering the glass ceiling, *Harvard Business Review*, vol 78 no.1 p26

Myerson D and Kolb D (2000) Moving out of the armchair: developing a framework to bridge the gap between feminist theory and practice, *Organization*, vol 7 no.4, pp553-571

National Steering Group on Equal Opportunities for Women in the NHS (1988) *Resource and Information Pack*. London, DHSS

Ngo H, Foley S, Wong A and Loi R (2003) Who gets more of the pie? Predictors of perceived gender inequity at work, *Journal of Business Ethics* vol 45 pp227-241

NHS Executive (1994) *Developing NHS Purchasing and GP Fundholding: Towards a Primary Care-Led NHS*. EL (94) 79. Leeds, NHS Executive

NHS Leadership Centre (2002) *NHS Leadership Qualities Framework*. London, NHS Modernisation Agency

NHS Management Executive (1992) *Women in the NHS: an implementation guide to Opportunity 2000*. London, Department of Health

Nieva V and Gutek B (1980) Sex effects on evaluation. *Academy of Management Review* vol 5 pp267-276

Oakley A (1972) *Sex, Gender and Society*. London, Temple Smith

Osborne D and Gaebler T (1992) *Reinventing Government*. Reading MA, Addison-Wesley

- Papanek H (1973) Men, women and work: reflections on the two-person career. *American Journal of Sociology*, vol 78 pp852-872
- Patton MQ (2002) *Qualitative research and evaluation methods*. Thousand Oaks, California, Sage
- Peck E (2006) Leadership and its development in healthcare. Chapter 19 in Walshe K and Smith JA [eds] *Healthcare Management*, pp323-341. Maidenhead, Open University Press
- Peck E and P (2006) *Beyond Delivery: policy implementation as sense-making and settlement*. Basingstoke, Palgrave Macmillan
- Peckham S and Exworthy M (2003) *Primary Care in the UK: Policy, Organisation and Management*. Basingstoke, Palgrave
- Plamping D (1991) The new NHS, *British Medical Journal* vol 302 no.6779, 737-8
- Plantin L, Sven-Axel M and Kearney J (2003) Talking and doing fatherhood: on fatherhood and masculinity in Sweden and England. *Fathering*, vol 1 no. pp3-26
- Polkinghorne DE (1988) *Narrative knowing and the human sciences*. Albany, State University of New York Press
- Pollitt C (1991) A public management for all seasons? *Public Administration* vol 69, no.1, 3-19
- Pollitt C, Harrison S, Hunter D and Marnoch G (1991) General management in the NHS: the initial impact 1983-88, *Public Administration*, vol 69 no.1, 61-83
- Pollock A (2004) *NHS plc*. London, Verso Press
- Pratchett L and Wingfield M (1994) *The Public Service Ethos in Local Government: A Research Report*. London, Commission for Local Democracy
- Raddon A (2002) Mothers in the Academy: positioned and positioning within discourses of the 'successful academic' and the 'good mother'. *Studies in Higher Education*, vol 27 no.4 pp387-403
- Redmond D (1993) *Women in management in the National Health Service*. MA Dissertation, University of Leicester
- Regen EL, Smith JA and Shapiro JA (1999) *First off the starting block: lessons from GP commissioning pilots for primary care groups*. Birmingham, HSMC
- Regen EL, Smith JA, Goodwin N, McLeod HST and Shapiro J (2001) *Passing on the Baton: final report of an evaluation of PCGs and PCTs*, HSMC, Birmingham
- Rivett G (1998) *From cradle to grave: fifty years of the NHS*. London, King's Fund

Rosenser J (1990) Ways Women Lead, Harvard Business Review vol 68 no.6, 119-125

Rosenthal G (2003) The healing effects of storytelling: on the conditions of curative storytelling in the context of research and counselling. Qualitative Inquiry, vol9 no.6, pp915-933

Ryan G (2001) The NHS Management Training Scheme (MTS): 1986-1998. Executive summary of the report on ex-trainees of MTS and how their careers have progressed since leaving the scheme. London: NHS Leadership Centre

Sandelowski M (1993) Rigor or rigor mortis: the problem of rigor in qualitative research revisited. Advances in Nursing Science, vol 16, pp1-8

Sartre JP (1938) La Nausee. Paris, Gallimard

Saunders G (2006) The NHS National Management Training Scheme: a chronology. Warwick, NHS Institute for Innovation and Improvement.

Schultze U and Stabell C (2004) Knowing what you don't know: discourses and contradictions in knowledge management research. Journal of Management studies, vol 41, no.4, pp549-73

Schwandt TA (1997) Qualitative inquiry: a dictionary of terms. Thousand Oaks, California, Sage

Schwartz FN (1987) Don't write women off as leaders. Fortune, vol115, pp185-8

Schwartz FN (1988) Corporate women: a critical business resource. Vital Speeches, vol54, pp173-6

Schwartzman LH (2002) Hate Speech, Illocution, and Social Context: A Critique of Judith Butler, Journal of Social Philosophy, vol 33 no.3, pp421-441

Sedikides C and Brewer MB (2002) Individual Self, Relational Self, Collective Self. Taylor and Francis Books Ltd.

Shotter J (2008) Dialogism and Polyphony in Organizing Theorizing in Organization Studies: Action Guiding Anticipations and the Continuous Creation of Novelty. Organization Studies vol 29, no.4, pp501-524

Simpson R (1998) Presenteeism, power and organizational change: long hours as a career barrier and the impact on the working lives of women managers. British Journal of Management, vol 9 special issue, ppS37-S50

Sinclair A (2007) Leadership for the disillusioned: moving beyond myths and heroes to leading that liberates. Crows Nest, New South Wales: Allen and Unwin

Sinclair A and Wilson V (2002) *New faces of leadership*. Melbourne, Melbourne University Press

Singh V and Vinnicombe S (2004) *The Female FTSE Report 2004*. Cranfield, Cranfield School of Management

Singh V and Vinnicombe S (2005) *The Female FTSE Report 2005*. Cranfield, Cranfield School of Management

Singh V and Vinnicombe S (2006) *The Female FTSE Report 2006*. Cranfield, Cranfield School of Management

Smith JA (2000) PhD study protocol. University of Birmingham, unpublished

Smith JA, Bamford M, Ham C, Scrivens E and Shapiro J (1997) *Beyond Fundholding: a mosaic of primary care led commissioning and provision in the West Midlands*. Birmingham and Keele, HSMC, Keele University and the West Midlands Office of the NHS Executive

Smith JA and Goodwin N (2006) *Towards managed primary care: the role and experience of primary care organisations*. Aldershot, Ashgate Publishing

Smith JA, Lewis R and Harrison A (2006) *Making commissioning effective in the reformed NHS*. The Health Policy Forum, London

Smith JA, Regen EL, Goodwin N, McLeod HST and Shapiro J (2000) *Getting into their stride: interim report of an evaluation of PCGs*, HSMC, Birmingham

Smith JA, Walshe, KMJ and Hunter DJ (2001) 'The reorganisation of the NHS', *British Medical Journal*, vol 323, pp1263-4

Smith P and Stewart R (1983) *Relative Career Progress of men and Women Graduates in NHS General Administration*. *Public Administration*, vol 61 no. 3, 318-323

Snell J (1998) *Chief executives: a gender for change*. *Health Service Journal*, vol 108, no.5608, pp24-27 (11 June 1998)

Spender D (1980) *Man Made Language*. London, Routledge and Kegan Paul

Stewart J and Walsh K (1992) *Change in the management of public services*, *Public Administration*, vol 70 no.4, pp 499-518

Stewart R and Smith P (1982) *Is the National Administrative Training Scheme meeting its objectives?* *Health Services Manpower Review*, 8:2

Stewart R, Smith P, Blake J and Wingate P (1980) *The district administrator in the National Health Service*. London, Pitman

Strong and Robinson (1990) *The NHS: Under New Management*. Buckingham, Open University Press

Sveningsson S and Alvesson M (2003) *Managing managerial identities*, *Human Relations*, vol 56, no.10, pp1163-93

Thatcher M (1993) *The Downing Street Years*. London, HarperCollins

Wall A (1998) *Ethics and management – oil and water?* Chapter 1 in Dracopoulou S [ed] *Ethics and Values in Health Care Management*. London, Routledge

Wallston BS and O’Leary BE (1991) *Sex makes a difference: differential perceptions of women and men*. *Review of personality and social psychology*, vol 2, pp9-41

Walter JA (1979) *A Long Way from Home*. Exeter, Paternoster Press

Walshe K and Smith JA (2001) ‘Drowning, not waving’, *Health Service Journal*, vol 111, no. 5768, 16 August 2001, pp 12-13

Warin J, Solomon Y, Lewis C and Langford W (1999) *Fathers, Work and Family Life*. Family Policy Studies Centre

Wayne S, Liden R, Kraimer M and Graf I (1999) *the role of human capital, motivation and supervisor sponsorship in predicting career success*. *Journal of Organizational Behavior*, vol 20 pp577-595

Weick K (1995) *Sensemaking in organizations*. London, Sage

West C and Zimmerman DH (1991) *Doing gender*. In Lorber J and Farrell S [eds] *The social construction of gender*, pp13-37. London, Sage

Wilkin D, Gillam S and Leese B [eds] (2000) *The National Tracker Survey of Primary Care Groups and Trusts: Progress and Challenges 1999/2000*. Manchester, National Primary Care Research and Development Centre

Wilkin D, Gillam S and Toleman A (2001) *The National Tracker Survey of Primary Care Groups: Progress and Challenges 1999/2000*. Manchester, National Primary Care Research and Development Centre

Wilkin D, Coleman A, Dowling B and Smith K (2002) *The National Tracker Survey of Primary Care Groups and Trusts 2001/02: Taking Responsibility?* Manchester, National Primary Care Research and Development Centre

Williams G (1984) *The genesis of chronic illness: narrative re-construction*. *Sociology of Health and Illness*, vol 6 no.2, pp175-200

Winstanley D (2001) *Existential stories on the myth and reality of motherhood*. *Electronic Journal of Radical Organization Theory*, August 2001

Wolf N (2002) *Misconceptions: Truth, lies and the unexpected on the journey to motherhood*. Vintage

Wyke S, Malbon G, Mays N and Goodwin N (2001) How was change achieved? Chapter 5 in Mays M, Wyke S, Malbon G and Goodwin N [eds] *The purchasing of health care by primary care organizations: an evaluation and guide to future policy*. Buckingham, Open University Press

Young H (1991) *One of Us*, final edition. London, Macmillan

Young A, Cady S and Foxon M (2006) Demystifying gender differences in mentoring: theoretical perspectives and challenges for future research on gender and mentoring. *Human Resource Development Review*, vol 5 no.2 pp 148-175

Trent Multi-Centre Research Ethics Committee

Derwent Shared Services
Laurie House
Colyear Street
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DE1 1LJ

Telephone: 01332 868905
Facsimile: 01332 868930

Chairman: Dr Robert Bing
Administrator: Jill Marshall

Your Ref:

19 March 2003

Dr Judith Smith
Senior Lecturer
Health Services Management Centre
University of Birmingham
HSMC, Park House
40 Edgbaston Park Road
Birmingham B15 2RT

Dear Dr Smith

MREC/03/4/018 - please quote this number on all correspondence
The role of the chief executive of primary care organisation in the NHS: Initial mapping survey questionnaire of NHS trust and primary care trust chief executives

The Chairman of the Trent MREC has considered the information/amendments submitted in response to the Committee's review of your application on 6 February 2003 as set out in our letter dated 14 February 2003. The documents considered were as follows:

- Application form dated 7 March 2003
- Protocol dated 7 March 2003
- Letter to Chief Executives dated 7 March 2003
- Survey questionnaire of NHS trust and PCT chief executives in the NHS – designated version 1 dated December 2002
- Chief investigator's CV – Dr Judith Smith

The members of the MREC present agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you our approval under Section C of the DoH "No local researcher" guidelines (November 2000 version 2) on the understanding that you will follow the conditions of approval set down below. The project must be started within three years of the date on which MREC approval is given.

While undertaking the review of your application the MREC noted the research involves the establishment of a new database for research purposes with no patient contact. For this reason you are not required to notify any LRECs when undertaking this research.

MREC Conditions of Approval

- The protocol approved by the MREC is followed and any changes to the protocol are undertaken only after MREC approval.

MREC/03/4/018 Ep C

- The MREC would expect to see a copy of any finalised questionnaires before they are used..
- You must complete and return to the MREC the annual review form that will be sent to you once a year, and the final report form when your research is completed.

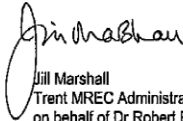
Legal and Regulatory Requirements

It remains your responsibility to ensure in the subsequent collection, storage or use of data or research sample you are not contravening the legal or regulatory requirements of any part of the UK in which the research material is collected, stored or used. If data is transferred outside the UK you should be aware of the requirements of the Data Protection Act 1998.

ICH GCP Compliance

The MRECs are fully compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997. The Standing Orders and a Statement of Compliance are available on the Internet at www.corec.org.uk.

Yours sincerely



Jill Marshall
Trent MREC Administrator
on behalf of Dr Robert Bing, Chairman

MREC/03/4/018 Ep C



West Midlands Multi-centre Research Ethics Committee

Chairman: Dr Robert Hawker
Co-ordinator: Mrs Anne McCullough

27 Highfield Road
Edgbaston
Birmingham
B15 3DP

27 July 2006

Tel: 0121 245 2544
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Ms Judith A Smith
Senior Lecturer
Health Services Management Centre, University of Birmingham
Park House, 40 Edgbaston Park Road,
Birmingham, West Midlands
B15 2RT

Dear Ms Smith

Full title of study: Mapping the population of chief executives of NHS trusts, primary care trusts, foundation trusts and care trusts in the NHS in England, with specific reference to the role, aspirations and experience of women chief executives.
REC reference number: 06/MRE07/41

Thank you for your letter of 17 July 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		17 July 2006
Investigator CV	1	18 May 2006
Protocol	1	18 May 2006
Letter of invitation to participant	2	17 July 2006
Participant Information Sheet	1	17 July 2006

The Central Office for Research Ethics Committees is responsible for the operational management of Multi-centre Research Ethics Committees

Participant Consent Form	2	17 July 2006
Response to Request for Further Information		17 July 2006
Survey Questionnaire	1	18 May 2006
Interview Schedule	1	18 May 2006
Invitation letter to Survey participants	2	17 July 2006
Supervisor's CV	1	18 May 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

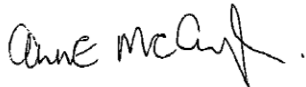
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/MRE07/41	Please quote this number on all correspondence
-------------	--

With the Committee's best wishes for the success of this project

Yours sincerely



**Anne McCullough [Mrs] on behalf of
Dr Robert Hawker
Chair**

Email: anne.mccullough@westmidlands.nhs.uk

Enc: : *Standard approval conditions*

Copy: Edward Peck
Health Services Management Centre
University of Birmingham
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Appendix 3: letter of invitation to interview

PERSONAL

Dear <name>

Re: Exploring the experience of women chief executives in the NHS – in-depth interviews

I am writing to invite you to take part in a one-to-one in-depth interview about your experience of being a woman chief executive in the NHS. The interview will form part of research that I am carrying out at HSMC for my PhD.

The research study is seeking to describe the population of NHS trust, foundation trust, PCT and care trust chief executives. The working hypothesis for the study is that PCT chief executives as a population differ from NHS trust/foundation trust chief executives, and this has been confirmed in stage one research carried out in 2003 in a national mapping survey of NHS chief executives (a survey carried out by Judith Smith at HSMC).

In stage two of the study, I am updating the national mapping survey of chief executives (this is to be sent out to all NHS trust, foundation trust, PCT and care trust chief executives in November 2006), seeking to identify any changes in the demography of the chief executive population over the period 2003-2006. Furthermore, I am carrying out in-depth qualitative research into the experiences of a sub-set of women chief executives, having determined in stage one research that gender is a significant issue in the differences between PCT and NHS trust chief executives, in relation to career history, choice of chief executive post, and experience of being a chief executive of an NHS organization.

I would like to carry out an interview with you during the autumn of 2006. The interview would be carried out by me, and be of a maximum two hours in length, and held at your office (unless you would prefer that it was held elsewhere, in which case alternative arrangements can be made). Areas to be covered in the interview would include: career history and choices; factors that motivate you in your chief executive role, factors that frustrate you in the role; the business and organizational priorities of the role; your conceptualization of the chief executive role in the NHS; the impact (if any) of gender on your role; and career plans for the future.

The interview will be completely confidential in nature and in my reporting, I will ensure that all findings are anonymised with nothing being able to be tracked back to you as an individual. A report of the findings of this research will be made available to all who are interviewed as part of this review, in advance of any publication of research findings in a PhD thesis or in other academic or professional publications.

I enclose an information sheet that gives more details about the study.

If you are willing and able to take part in an interview, I would be grateful if you could complete the attached consent form and return it to me in the enclosed reply-paid envelope. I will then make an arrangement with your office for a mutually convenient date and time for the interview.

If you would like to see a copy of the full research protocol for this study, or if you have any queries about any aspect of the research, please contact me at HSMC on 0121 414 7073 (direct) or email j.a.smith.20@bham.ac.uk.

Thank you in advance for considering this request.

Yours sincerely

Judith Smith
Senior Lecturer
HSMC, University of Birmingham

Cc Edward Peck, Tim Freeman

Participant information sheet

Exploring the experience of women chief executives in the National Health Service

'You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This research is being carried out as part of PhD study being undertaken by Judith Smith, Senior Lecturer at the Health Services Management Centre at the University of Birmingham.

The main purpose of this study is to try and answer the question:

- who are the chief executives of primary care trusts in England, and in what ways, if any, do they differ from the population of chief executives of NHS trusts?

In exploring this question in the earlier phase of this study (2003-2005), it has emerged that the population of chief executives of primary care trusts differs significantly from that of NHS trusts. These differences include: gender; age; salary; and career history.

In this second stage of research, two things are being done:

firstly, the researcher is carrying out a follow-up postal questionnaire survey of all chief executives of primary care trusts (PCTs), care trusts, NHS foundation trusts and NHS trusts in England as a means of identifying any demographic change over the period 2003-2006.

secondly, the researcher is undertaking a more in-depth study of the aspirations, role and experience of women chief executives. The rationale for this is the fact that

there are proportionately more women in chief executive roles in primary care trusts, and the researcher wants to explore why it is that more women have been attracted to these posts in comparison with parallel positions in NHS trusts, where there has been little increase in the proportion of women chief executive postholders over the past decade.

*The **primary hypothesis** is that gender is a significant factor in the 'difference' of PCT chief executives from their NHS trust (and foundation trust) counterparts.*

***Secondary hypotheses** are as follows:*

- that there are specific factors associated with PCTs that make women more likely to choose a chief executive role in a PCT, rather than in an NHS trust.

- that there are specific factors associated with NHS trusts that make women less likely to choose a chief executive role in an NHS trust, rather than in a PCT.

- that women's motivations about choice of career within health services differ, to some extent, from those of men.

- that there are specific factors that affect the career choices of women within health services management.

- that there continues to be some sex-role stereotyping of women's roles in health services management (Alban Metcalfe, 1989) and that this affects the gender balance of the overall NHS chief executive population.

- that women may conceptualise the role and skill-set of a health service chief executive in a different way from their male counterparts.

- that women health service chief executives may set different business and organisational priorities from those of their male equivalents.

- that there are factors associated with large NHS trusts that dissuade women from applying for chief executive posts in such organisations.

- that women chief executives are less likely than their male counterparts to stay in post for as long a period of time.

- that women chief executives are more likely than their male colleagues to lose their chief executive post in the 2006 reorganisation of PCTs in the NHS.

Why have I been chosen?

The researcher wishes to carry out an in-depth and semi-structured interview with twelve women NHS chief executives, six from PCTs and six from NHS trusts or NHS foundation trusts.

Chief executives have been selected for invitation for interview using a two-stage process. A database of all women chief executives in the NHS in England has been derived from the total database of NHS chief executives (Binley's, 2006). Sampling has been carried out from this population, using the following dimensions:

- equal numbers of women NHS trust and PCT chief executives (ten of each category*
- to allow for non-response to invitation letter)*

- geographical spread of respondents across England (no more than two in any strategic health authority area)*

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be contacted by Judith Smith in order to arrange an interview with you during the autumn of 2006. The interview will be carried out by Judith Smith, and be of a maximum two hours in length, and held at your office (unless you would prefer that it was held elsewhere, in which case alternative arrangements can be made).

Areas to be covered in the interview will include: career history and choices; factors that motivate you in your chief executive role, factors that frustrate you in the role; the business and organizational priorities of the role; your conceptualization of the chief executive role in the NHS; the impact (if any) of gender on your role; and career plans for the future.

The interview will be completely confidential in nature and in her reporting, the researcher will ensure that all findings are anonymised with nothing being able to be tracked back to you as an individual.

A report of the findings of this research will be made available to all who are interviewed as part of this review, in advance of any publication of research findings in a PhD thesis or in other academic or professional publications.

The researcher will take handwritten notes and will also make a tape recording of the interview, if you give consent to this, and this will be explained and checked on the day of the interview. If you give consent to this, only the principal investigator and her two PhD supervisors will have access to data on a named basis. Transcription will be carried out by a transcriber who has no access to the respondent's identity.

The student, supervisors and transcriber will be bound by the University of Birmingham's rules on confidentiality of research data.

You have the right to see all data that are held on you. If you would like to receive a copy of the full transcript of the interview for checking, please advise the researcher and a copy will be provided to you for checking following the interview.

The tape will be stored in accordance with the University of Birmingham's procedures for the safe and confidential storage of research data. The tape will be coded and not have on it any record of your name. Data stored on university computers and on the principal investigator's laptop computer (that is the property of the University of Birmingham) will be coded in such a way that they could not be identified or linked with any individual. Data will be stored securely for five years, and then destroyed in a secure manner, in accordance with University of Birmingham protocols.

Direct quotations from the interview may be used in publications resulting from this research. Any quotations used will be fully anonymised in a way that precludes any identification of individuals or their organization.

What do I have to do?

You should complete the enclosed consent form and return it to Judith Smith at HSMC using the prepaid envelope.

If you have agreed to take part in the study, Judith will contact your office to arrange a mutually convenient time for the interview to be carried out. Once the interview is arranged, Judith will confirm the date, time, and location in writing and will explain in the letter about what will be covered in the discussion.

If you returned the form indicating that you do not agree to take part in the study, you will not be contacted again about this element of the research.

What are the possible disadvantages of taking part?

The main disadvantage involved in taking part in this study is the need to find two hours for the interview to be held. The researcher will do all she can to make sure that the arrangement for the interview is made at a time that is of maximum convenience to the participant and in a location of their choosing.

What are the possible benefits of taking part?

Taking part in this research will enable an in-depth exploration of the role and experience of women chief executives in the NHS. This is a topic that has received little research attention in recent years. The results of this research, when published, will provide important evidence to policy makers and managers in health care systems, and in the NHS in particular, about the experiences of women chief executives, and of the issues associated with working at chief executive level in a primary care trust, as opposed to in an NHS trust or an NHS foundation trust. In

turn, the results of this research have the potential to influence recruitment, retention and development policies within NHS and wider health care management.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do her best to answer your questions (0121 414 7073). If you remain unhappy and wish to complain formally, you can do this through the University of Birmingham. Any complaint about the way in which you have been dealt with in this study should be addressed in the first instance to Professor Chris Skelcher, Director of Research, School of Public Policy, University of Birmingham (c.k.skelcher@bham.ac.uk or 0121 414 4962).

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential as set out above.

What will happen if I don't want to carry on with the study?

If you withdraw from the study, we will destroy the record of your interview, both in taped and handwritten form.

What will happen to the results of the research study?

The results of the research study will be written up in the PhD thesis of the researcher. This thesis, if successfully examined, will be deposited in the Library of the University of Birmingham. It is also intended that results of the research will be written up for wider publication in academic and professional journals.

A copy of a summary of the research findings will be made available to the participants in these research interviews, in advance of any publication in the PhD thesis or other journals.

Who is organising and funding the research?

This PhD research is being supervised by Professor Edward Peck and Dr Tim Freeman at HSMC at the University of Birmingham. There is no funding of the research – it is being carried out as Judith Smith's personal PhD study.

Who has reviewed the study?

The study has been given a favourable ethical opinion for conduct in the NHS by the West Midlands Multi-centre Research Ethics Committee.

Contact details

For further information about this study, or if you have concerns about the research at any point, please contact:

*Judith Smith
Senior Lecturer
Health Services Management Centre
40 Edgbaston Park Road
Birmingham
B15 2RT*

j.a.smith.20@bham.ac.uk

0121 414 7073

Thank you very much for taking the time to read this information sheet and for considering taking part in this research.



Study Number: 06/MRE07/41
Chief Executive Number:

CONSENT FORM

Title of Project: Mapping the population of chief executives of NHS Trusts, primary care trusts, foundations trusts and care trusts in the NHS in England, with specific reference to the role, aspirations and experience of women chief executives

Name of Researcher: Judith Smith, Senior Lecturer, HSMC, University of Birmingham

Please initial box

- 1. I confirm that I have read and understood the information sheet dated 13 July 2005 (version one) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation in voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that data collected during the study may be looked at by responsible individuals from the University of Birmingham where it is relevant to my taking part in this research. I give permission for these individuals to have access to these data.
4. I understand that direct quotations from the research interview may be used in publications arising from this research, and that these will be fully anonymised in a way that precludes any identification of individuals or their organisation.
5. I agree to take part in the study.

Name of Chief Executive Date Signature

Researcher Date Signature

When completed, 1 for Chief Executive participant and 1 for researcher site file

If you have consented to take part in this study, please complete the details below:

Name: _____

Job Title: _____

Organisation: _____

Address: _____

Tel. No: _____

Email address: _____

Name of PA/Secretary: _____

**with whom an appointment
for interview can be made:**

Telephone number of PA/Secretary: _____

Email address of PA/Secretary: _____

Please return to Judith Smith at HSMC using enclosed pre-paid envelope

Thank you

**University of Birmingham
Health Services Management Centre**

**Exploring the experience of women chief
executives in the NHS**

*In-depth Interviews
November/December 2006*

Name:

Job:

Organisation:

Date of interview:

Location of interview:

Interviewer:

This PhD research study is seeking to describe the population of PCT chief executives in terms of its demography, and to draw comparisons with the population of NHS trust and foundation trust chief executives.

The working hypothesis is that PCT chief executives do as a population differ from NHS trust chief executives, and this has been confirmed in stage one research carried out in 2003.

In stage two, HSMC is updating a national survey of chief executives previously carried out in 2003, identifying any changes in the demography of this population.

Furthermore, we are carrying out in-depth qualitative research into the experiences of a sub-set of women chief executives, having determined in stage one research that gender is a significant issue in the differences between PCT and NHS trust chief executives, both in relation to career history, choice of chief executive post, and issues such as longevity in post.

In this interview, I want to explore some of the issues associated with your career history, choice of chief executive post, and experience of being a chief executive of an NHS organisation.

This interview is completely confidential in nature, and in our reporting, we will ensure that all findings are anonymised with nothing being able to be tracked back to you as an individual.

A report of the findings of this research will be made available to all who are interviewed as part of this review, in advance of any publication of research findings in a PhD thesis or in other academic or professional publications.

Before proceeding with the interview, I would welcome any questions that you have about this research and this interview.

I would like to make a tape recording of this interview, as well as taking contemporaneous notes. The tape recording and notes will be stored securely in line with University of Birmingham data protection procedures and only I and my PhD supervisor will have access to the data. Are you prepared to give consent to the recording of the interview?

Name.....

I confirm that I give consent to the recording of this interview:

Signature.....

Date.....

Questions

1. Could you give me an overview of your career to date? Tell me your story...

2. What factors have influenced your career choices to date?

Prompt for desire for promotion, salary, national policy developments, career coaching and advice, family or other personal circumstances.

3. What were the reasons for your choice to become a chief executive of an NHS organisation?

Prompt for why a PCT or NHS trust CE and not the other...

4. As a woman, what have been the major influences on your career?

Prompt for people, books, experience, family.

5. What factors motivate you in your chief executive role?

Prompt for what is satisfying or not about the role, frustrations associated with the role, any way in which the motivating factors have changed over time.

6. What do you find attractive about your organisation?

7. What business and organisational priorities have you set for your current role?

Prompt for financial balance, service change, organisational development, health improvement, central policy priorities

8. How did you conceptualise and envisage the chief executive role at the time of your appointment?

9. Has your conceptualisation of the chief executive role changed subsequently? If so, how?

10. What sense do you make if your role as a chief executive? What does it mean to you?

Prompt for what is satisfying about the role, what they find uncomfortable about it

11. What are your career plans and intentions for the future?

Prompt for the reasons for these, any actions taken to facilitate the plans

HSMC, Birmingham
November 2006

Appendix 7

Example of a core story

This appendix sets out one example of the stories of ten women chief executives in the NHS. The story is presented as a ‘core story’ (Emden, 1998) that seeks to capture the importance and heart of the story. Each core story was derived as part of a process of narrative analysis of the full transcript of the interview. In developing the core stories, the researcher worked from an assumption that the ‘career story’ part of each narrative was crucial to the subsequent analysis of the portrayal of self and selves through the narrative of career. Thus the researcher included and worked with the material that described the chief executives’ career journey, their assessment of factors that had influenced the journey, the intersection of home and family life with career, the conceptualisation by the women of their role as a chief executive, and what were felt to be powerful recurring stories of discrimination, subversion, and patronage.

Chief executive G has given her consent to the inclusion of this story within the thesis.

Chief executive G

I left school after my A levels and wanted to be an actress. I ended up as a secretary within a Community Health Council in 1975. After two years in the CHC, I went on to be a planning administrator in a Regional Health Authority, and then after a couple of years I decided I wanted to be closer to patients and moved to a large teaching hospital working with James Compton [a well-known and respected NHS manager and academic] as a planning administrator. This was a golden time for me, with very good supportive managers (who were men), working with a group of women colleagues, making things happen in the hospital. Then Graham Allan [a well-known and respected NHS manager who has worked at a very senior level] arrived at the hospital and things got even better. The hospital was merging with another teaching hospital, and I was being asked to expand my role across two hospitals, but I decided to have a baby and a career break. I then went and had a baby, and planned to have 5 years off work. That lasted 6 weeks after he was born, however, and I thought I would go spare if all I did was do child rearing for 5 years. So I went and got a job with a Polytechnic, as a part-time lecturer. After a year they asked me to go full-time and be course director, which I did. However, my husband’s job moved and so I dropped everything, moved house, and had a second baby while I was about it and being uprooted. By now, general management was being introduced into the NHS and I was thinking about getting back into the saddle.

Eventually I got a planning job in a large teaching hospital, and felt that I was getting back into my career again. In 1989, a UGM post came up at a large neighbouring hospital, and I applied in order to signal that I felt I was ready for such a post – to my complete astonishment, I got it! I had a post across two hospitals, and was the first woman manager outside nursing that the hospital had ever had. It was bloody hard work but I had a whale of a time for four years and we managed to make some significant inroads. I then had another period of questioning about my career. It was 1992, NHS trusts were being set up and I felt I lacked access to the overall trust board. I was offered a senior executive post at a nearby trust, so I went in to help the

chief executive set up the new business arrangements and clinical management structures. I started to apply for chief executive posts when I was 38. I wasn't shortlisted for one or two and started to wonder why. I had never experienced the glass ceiling before then, nor had any sense of the ceiling, and was working with the NHS Women's Unit doing some interesting stuff. However I got the chief executive post at a district general hospital (the first chief executive interview I had), and did four and a half years there. I heard afterwards that it took the panel a long time to be persuaded that I was the appropriate person for the job.

I then got a bit bored, started to reflect. A major teaching hospital chief exec post then came up and I chatted with the relevant regional director about this. He said that I could apply but would not be appointed, for the doctors there would never wear a woman chief executive, however good I was. He made it clear that for this part of the world, a woman teaching hospital chief executive would just not be acceptable. So I decided not to put myself through that. I went to the region in 2000 on secondment from my trust, as offered by the regional director, for I wanted to understand policy and strategy development – people thought that I must be in trouble and in need of rescuing, but I was fine and just in need of refreshment after years in operational management in trusts. Then *Shifting the Balance of Power* came along and it became clear regions were doomed. My job changed almost overnight and became one of helping the regional director to sort out the restructuring. I decided that I wanted to get back closer to patients and started to apply for chief executive posts again. I felt that I had lots of experience and that people would absolutely gobble me up. I was shortlisted for five trust chief exec posts, but was not appointed, and felt bewildered about this. An external assessor for two of the posts, who I knew well (the regional director I had worked with recently), told me that I was always well above the line, but they were not selecting me because: a) I was a woman and chairs of trusts felt exposed and wanted the protection of someone like themselves b) I had voluntarily left a trust and had gone and done soft and fluffy stuff, so could not convince panels of my rigour – I was too much of a risk for them. I kept asking my regional director what I was doing wrong, and he said nothing - I just needed to make myself less risky, and demonstrate that I had the balls to do a chief executive job.

So I decided to leave the regional office. I got a post as an interim chief executive, and I did this and loved it, but I did not want to stay as I didn't think the trust was sustainable in the long run. I agreed with the SHA that I would recruit a new top team and then go. This post [that I am in now] then came up and the regional director told me it was a great opportunity so have another go – I got the post, have changed the top team completely and am beginning to change the culture – all very exciting.

When I went back to full-time NHS management after having the children they were five years, and 17 months. We had a nanny for the first six months I was working but I was really unhappy about someone seeing more of the baby than either of her parents. I talked to my husband about part-time work, but he said that I was on a steeper career trajectory than him and had more opportunities to progress. We were earning the same, and he suggested that he give up work. You could have knocked me down with a feather, for he is not exactly a new man, nor the archetypal househusband. We role-swapped and he was fantastic at bringing up the kids, he stayed at home until they were eight or nine, and at a huge cost to his career. Whole family ethos has been that mum's career is the bread-winning career and dad's main

job is to see to the kids. I don't think I could have done the work that I have done if I had bought in childcare. I see the challenge it gives to people – I was like a male chief executive really in that the childcare was always there and I could come home late if I had to. I take my hat off to women who manage it. I'm a very proud mum and my family is incredibly important to me. I feel so much gratitude to my husband for that he gave up, and hence I make a priority of tending that family unit so that it will remain strong. Years ago, all the women who were senior were unmarried and/or childless. I decided that is I was going to buck that trend, I was not going to take my family for granted. The children have left home and it is a source of sadness that I was not there for them as much as I could have been. But we made our decisions and they seem to have worked out. The sacrifice that I have made on the way is that I have not got a strong network of friends – there are a couple of close women friends who I will talk to by phone two to three times a year, but career and family didn't leave time for friends really.

My single most important piece of career advice to people is find a boss who can stretch you, challenge you, but who supports and rates you. For me, these bosses have been [names of five very senior male chief executives in the NHS]. This is a group of men who have recognised something in me that meets their needs in their organisation and have let me rip in their organisation. They have taken risks with me. Another theme in my career has been that I have often had to create credibility from a position where all I had was my personality – it is quite scary really and more so as I get older and realise how fragile that is.

I am the oldest child and have two brothers and I went to an all girls' school. I have always been at completely at home with men and always thought I could do what men could. Up until I appointed two senior managers when a chief executive, I had always been the only senior woman anywhere I worked. The NHS Women's Unit showed me how to be 'masculine' (to be more masculine than men to be accepted), but I have adapted that. I chair the regional acute trust chief executives' meeting and play a mediation role when some of them strike poses – I seek a consensus beyond 'might is right' approach. Many male hospital chief executives are competitive and very transactional, treating the job like the general who controls the army. They fill the leadership frame themselves. I am transformational and those men see this as very much the weaker style, but I have adopted this because I cannot do the stamping around stuff. A real shame that in 2000 we started talking about transformational leadership and then that all disappeared. If we really do want to develop a different cadre of leaders for the future, we really do need to address that. The management culture of the service is target-focused and strongly transactional – real dissonance between management standards and the culture. System seems to reward behaviour that is about marching around frightening people. Too much on what and not about how we do things.

I feel really proud of being a woman chief executive. My daughter tells me that women's equality is nonsense for we are all equal. But I realise that I have done well to survive. I know that to continue to survive, I've got to continue to be better than men. We will know we have got true equality when mediocre people are appointed to top, mediocre women are appointed to top jobs, like mediocre men are.

*University of Birmingham
Health Services Management Centre*

*Survey questionnaire of
NHS trust and primary care trust chief executives in the NHS*

YOUR ORGANISATION

1. Which of the descriptions below best fits your organisation?

- NHS trust
- Primary care trust
- Other (please specify).....

2. Please indicate which services are provided by your organisation (please tick all that apply):

- Acute and general hospital services
- Mental health services
- Services for people with learning difficulties
- Community health services
- Primary care services
- Services for older people
- Ambulance services
- Other (please specify).....

3. What is the total revenue budget of your organisation?

£.....

4. How many people (head count) are employed by your organisation?

.....

5. What was the date of the establishment of your organisation as an NHS trust or primary care trust?

Month: Year:

PERSONAL INFORMATION

6. When did you take up this current post of chief executive?

Month: Year:

7. What is the status of your employment? (tick box that applies)

Full-time Part-time Job share

8. What is your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for this post? (tick box that applies)

Less than £60,000	<input type="radio"/>	£100,000 – 109,999	<input type="radio"/>
£60,000 – £69,999	<input type="radio"/>	£110,000 – 119,999	<input type="radio"/>
£70,000 - £79,999	<input type="radio"/>	£120,000 – 129,999	<input type="radio"/>
£80,000 - £89,999	<input type="radio"/>	£130,000 +	<input type="radio"/>
£90,000 - £99,999	<input type="radio"/>		

9. What was your job immediately prior to taking up your current post?

Job title:

What type of organisation did you work in?

NHS trust

Primary care group

Primary care trust

Health authority

Health board

Local authority

Other (please specify)

What was your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for your previous post? (tick box that applies)

Less than £40,000 £90,000 - £99,999

£40,000 – £49,999 £100,000 – 109,999

£50,000 - £59,000 £110,000 – 119,999

£60,000 – £69,999 £120,000 – 129,999

£70,000 - £79,999 £130,000 +

£80,000 - £89,999

10. Are you:

Male Female

11. What is your age? (tick box that applies)

30 or under 50-54

31-35 55-59

36-39 60+

40-44

45-49

12. How would you describe your ethnic origin? (tick box that applies)

White **Error! Reference source not found.**

Indian **Error! Reference source not found.**

Black Caribbean **Error! Reference source not found.**

Pakistani **Error! Reference source not found.**

Black African **Error! Reference source not found.**

Bangladeshi **Error! Reference source not found.**

Black Other **Error! Reference source not found.** O

Asian Other **Error! Reference source not found.** O

Chinese **OError! Reference source not found.**

Other Origins **Error! Reference source not found.** O

13. Are you registered disabled?

Yes No

14. What is/are your highest educational qualification(s)? (tick box[es] that apply)

GCSE/O levels

A levels

Bachelors degree

Postgraduate diploma

Masters degree

Doctorate

Other (please specify)

.....

15. Do you hold any professional qualification(s)? (please tick box[es] that apply)

CertHSM

DipHSM

RGN

MRCP

MRCGP

MFPHM

Other (please specify).....

Feedback on questionnaire and covering letter

16. Did you have any difficulty in completing any part of this questionnaire?

Yes No

17. If you have answered yes to this question, please explain what you found difficult about the questionnaire:

.....
.....
.....
.....
.....
.....
.....

18. Is there anything else you would like to add about the questionnaire or the covering letter?

.....
.....
.....
.....

Thank you very much for your co-operation in completing this questionnaire – please return this to HSMC using the prepaid label provided by Friday 9 August 2002. Alternatively, you may fax your response to 0121 414 7051 marked for the attention of Judith Smith, Senior Lecturer.

*University of Birmingham
Health Services Management Centre*

*Survey questionnaire of
NHS trust and primary care trust chief executives in the NHS*

YOUR ORGANISATION

1. Which of the descriptions below best fits your organisation?

- NHS trust
- Primary care trust
- Other (please specify).....

2. Please indicate which services are provided by your organisation (please tick all that apply):

- Acute and general hospital services
- Mental health services
- Services for people with learning difficulties
- Community health services
- Primary care services
- Services for older people
- Ambulance services
- Other (please specify).....
-

3. What is the total revenue budget of your organisation?

£.....

4. How many people (head count) are employed by your organisation?

.....

5. What was the date of the establishment of your organisation as an NHS trust or primary care trust?

Month: Year:

PERSONAL INFORMATION

6. When did you take up this current post of chief executive?

Month: Year:

7. What is the status of your employment? (tick box that applies)

Full-time Part-time Job share

8. What is your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for this post? (tick box that applies)

Less than £60,000	<input type="radio"/>	£100,000 – 109,999	<input type="radio"/>
£60,000 – £69,999	<input type="radio"/>	£110,000 – 119,999	<input type="radio"/>
£70,000 - £79,999	<input type="radio"/>	£120,000 – 129,999	<input type="radio"/>
£80,000 - £89,999	<input type="radio"/>	£130,000 +	<input type="radio"/>
£90,000 - £99,999	<input type="radio"/>		

9. What was your job immediately prior to taking up your current post?

Job title:

What type of organisation did you work in?

NHS trust

Primary care group

Primary care trust

Health authority

Health board

Local authority

Other (please specify)

What was your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for your previous post? (tick box that applies)

Less than £40,000 £90,000 - £99,999

£40,000 – £49,999 £100,000 – 109,999

£50,000 - £59,000 £110,000 – 119,999

£60,000 – £69,999 £120,000 – 129,999

£70,000 - £79,999 £130,000 +

£80,000 - £89,999

10. Are you:

Male Female

11. What is your age? (tick box that applies)

30 or under 50-54

31-35 55-59

36-39 60 +

40-44

45-49

12. How would you describe your ethnic origin? (tick box that applies)

White **Error! Reference source not found.** Indian
Error! Reference source not found.
Black Caribbean **Error! Reference source not found.**
Pakistani **Error! Reference source not found.**
Black African **Error! Reference source not found.**
Bangladeshi **Error! Reference source not found.**

- Black Other **Error! Reference source not found.** Asian
- Other **Error! Reference source not found.**
- Chinese **Error! Reference source not found.** Other
- Origins **Error! Reference source not found.**

13. Are you registered disabled?

- Yes No

14. What is/are your highest educational qualification(s)? (tick box[es] that apply)

GCSE/O levels

A levels

Bachelors degree

Postgraduate diploma

Masters degree

Doctorate

Other (please specify)

15. Do you hold any professional qualification(s)? (please tick box[es] that apply)

CertHSM

DipHSM

RGN

MRCP

MRCGP

MFPHM

Other (please specify).....

16. Is there anything else you would like to add?

.....
.....
.....
.....
.....
.....
.....

Thank you very much for your co-operation in completing this questionnaire – please return this to HSMC using the prepaid label provided by <day, date and month>.

PERSONAL

Dear <name>

Survey of NHS chief executives

I am writing to ask you to take part in a confidential survey of NHS chief executives. **The survey forms a baseline for further work exploring the extent to which, if at all, primary care trust (PCT) chief executives differ in their background and way of working from chief executive colleagues in NHS trusts.** This study forms part of my PhD study exploring the role of chief executives of PCTs.

The aim of the survey is to find out basic demographic details about chief executives in NHS trusts and PCTs, including their career history and professional qualifications. The data collected in the survey will be used to form an overall profile of chief executives in NHS trusts and PCTs and to assess the degree to which, if at all, chief executives in PCTs differ from colleagues in NHS trusts in terms of their background and experience.

The survey is **entirely confidential** and only myself and my colleague Professor Peter Spurgeon will have access to data collected in the survey. The results of the survey may be published in professional and academic journals, but no results will be used in any way that would identify respondents. Please note that I have obtained NHS Multi-centre Research Ethics Committee approval for this study.

If you are willing to take part in the survey, which should take just five minutes of your time, please fill in the enclosed questionnaire, and return it using the reply paid label provided to HSMC, by <day, date and month> **2003**.

If you have any queries about the survey, please call me on (0121) 414 7073 or email on j.a.smith.20@bham.ac.uk. Thank you in advance for taking part.

Yours sincerely,

**Judith Smith
Senior Lecturer
Health Services Management Centre**

Enc

Cc P Spurgeon

PERSONAL

Dear <name>

Survey of NHS chief executives

I am writing to ask you to take part in a confidential survey of NHS chief executives. **The survey forms the follow-up stage of a survey of NHS chief executives carried out by HSMC in 2003, and is a key part of a study that is exploring the extent to which, if at all, primary care trust (PCT) chief executives differ in their background and way of working from chief executive colleagues in NHS trusts and foundation trusts.**

The 2003 survey revealed that there are some significant differences in the two populations of NHS chief executives (trust and PCT) and this second survey is intended to both update the national demographic profile of NHS chief executives and also to explore the degree to which current NHS reorganization will have had an impact on this profile. This study forms part of my PhD study exploring the role of chief executives of PCTs.

The aim of the survey is to find out basic demographic details about chief executives in NHS trusts, NHS foundation trusts and PCTs, including their career history and professional qualifications. The survey is **entirely confidential** and only myself and my colleagues and PhD supervisors Professor Edward Peck and Dr Tim Freeman will have access to data collected in the survey. The results of the survey will be published in professional and academic journals, but no results will be used in any way that would identify respondents. Please note that I have obtained NHS Multi-centre Research Ethics Committee approval for this study.

If you are willing to take part in the survey, which should take just ten minutes of your time, please fill in the enclosed questionnaire, and return it using the reply paid label provided to HSMC, by **Monday 11 December 2006**.

Please note that if you do not respond to this questionnaire, you will receive a follow-up letter and a further copy of the questionnaire, one month following the date on this letter. There will however be no further chasing for replies beyond the single follow-up letter.

If you have any queries about the survey, please call me on (0121) 414 7073 or email on j.a.smith.20@bham.ac.uk. Thank you in advance for taking part.

Yours sincerely,

Judith Smith
Senior Lecturer
Health Services Management Centre

Enc

Cc E Peck, T Freeman

*University of Birmingham
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*Survey questionnaire of
NHS trust, foundation trust, primary care trust and care trust chief
executives in the NHS*

<i>YOUR ORGANISATION</i>

1. Which of the descriptions below best fits your organisation?

- | | |
|-----------------------------|-----------------------|
| NHS trust | <input type="radio"/> |
| NHS foundation trust | <input type="radio"/> |
| Primary care trust | <input type="radio"/> |
| Care trust | <input type="radio"/> |
| Other (please specify)..... | |

2. Please indicate which services are provided by your organisation (please tick all that apply):

- | | |
|--|-----------------------|
| Acute and general hospital services | <input type="radio"/> |
| Mental health services | <input type="radio"/> |
| Services for people with learning difficulties | <input type="radio"/> |
| Community health services | <input type="radio"/> |
| Primary care services | <input type="radio"/> |
| Services for older people | <input type="radio"/> |
| Services for women and children | <input type="radio"/> |

Ambulance services

Other (please specify).....

.....

3. What is the total revenue budget of your organisation for the year 2006-2007?

£.....

4. How many people (head count) are currently employed by your organisation?

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5. What was the date of the establishment of your organisation as an NHS trust, NHS foundation trust, primary care trust, care trust or other organisation?

Month: Year:

PERSONAL INFORMATION

6. When did you take up this current post of chief executive?

Month: Year:

7. What is the status of your employment? (tick box that applies)

Full-time

Part-time

Job share

8. What is your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for this post? (tick box that applies)

- | | | | |
|-------------------|-----------------------|--------------------|-----------------------|
| Less than £60,000 | <input type="radio"/> | £100,000 – 109,999 | <input type="radio"/> |
| £60,000 – £69,999 | <input type="radio"/> | £110,000 – 119,999 | <input type="radio"/> |
| £70,000 - £79,999 | <input type="radio"/> | £120,000 – 129,999 | <input type="radio"/> |
| £80,000 - £89,999 | <input type="radio"/> | £130,000 – 139,999 | <input type="radio"/> |
| £90,000 - £99,999 | <input type="radio"/> | £140,000 – 149,999 | <input type="radio"/> |
| | | £150,000 + | <input type="radio"/> |

9. What was your job immediately prior to taking up your current post?

Job title:

What type of organisation did you work in?

- | | |
|----------------------------|-----------------------|
| NHS trust | <input type="radio"/> |
| NHS foundation trust | <input type="radio"/> |
| Primary care group | <input type="radio"/> |
| Primary care trust | <input type="radio"/> |
| Health authority | <input type="radio"/> |
| Strategic health authority | <input type="radio"/> |

Health board

Local authority

Other (please specify)

What was your basic gross salary (full-time equivalent and exclusive of bonuses and performance awards) for your previous post? (tick box that applies)

- | | | | |
|-------------------|-----------------------|--------------------|-----------------------|
| Less than £40,000 | <input type="radio"/> | £90,000 - £99,999 | <input type="radio"/> |
| £40,000 – £49,999 | <input type="radio"/> | £100,000 – 109,999 | <input type="radio"/> |
| £50,000 - £59,000 | <input type="radio"/> | £110,000 – 119,999 | <input type="radio"/> |
| £60,000 – £69,999 | <input type="radio"/> | £120,000 – 129,999 | <input type="radio"/> |
| £70,000 - £79,999 | <input type="radio"/> | £130,000 – 139,999 | <input type="radio"/> |
| £80,000 - £89,999 | <input type="radio"/> | £140,000 – 149,999 | <input type="radio"/> |
| | | £150,000 + | <input type="radio"/> |

10. Are you:

Male Female

11. What is your age? (tick box that applies)

- | | | | |
|-------------|-----------------------|-------|-----------------------|
| 30 or under | <input type="radio"/> | 50-54 | <input type="radio"/> |
| 31-35 | <input type="radio"/> | 55-59 | <input type="radio"/> |
| 36-39 | <input type="radio"/> | 60 + | <input type="radio"/> |
| 40-44 | <input type="radio"/> | | |
| 45-49 | <input type="radio"/> | | |

12. How would you describe your ethnic origin? (tick box that applies)

- | | | |
|-----------------|---|-----------------------|
| White | Error! Reference source not found. | <input type="radio"/> |
| Indian | Error! Reference source not found. | <input type="radio"/> |
| Black Caribbean | Error! Reference source not found. | <input type="radio"/> |
| Pakistani | Error! Reference source not found. | <input type="radio"/> |
| Black African | Error! Reference source not found. | <input type="radio"/> |
| Bangladeshi | Error! Reference source not found. | <input type="radio"/> |
| Black Other | Error! Reference source not found. | <input type="radio"/> |
| Asian Other | Error! Reference source not found. | <input type="radio"/> |
| Chinese | Error! Reference source not found. | <input type="radio"/> |
| Other Origins | Error! Reference source not found. | <input type="radio"/> |

13. Are you registered disabled?

Yes No

Do you consider yourself to have a disability (even if not registered as disabled)

Yes No

14. What is/are your highest academic educational qualification(s)? (tick box[es] that apply)

GCSE/O levels

A levels

Bachelors degree

Postgraduate diploma

Masters degree

Doctorate

Other (please specify)

15. Do you hold any professional qualification(s)? (please tick box[es] that apply)

CertHSM

DipHSM **O**

RGN **O**

MRCP **O**

MRCGP

MFPHM

Other (please specify).....

16. Is there anything else you would like to add?

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Thank you very much for your co-operation in completing this questionnaire – please return this to HSMC using the prepaid label provided by Monday 11 December 2006.