

LiNEA-R

Retaining Nurses in the Workforce

Taking forward the career development work of the
LiNEA Project

EXECUTIVE SUMMARY

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RESEARCH BACKGROUND

INTRODUCTION

Purpose of the research

This report focuses on retention and development of nurses in the workforce through the implementation of evidence based research about the support and learning needs of newly qualified nurses and progression to management roles.

It evaluates the effects of initiatives implemented by the Trust to develop nurses, based on the findings of a previous project, 'Learning in Nursing, Engineering and Accountancy (LiNEA) Project' carried out by the Universities of Sussex and Brighton. The evidence base has been extended further in the research, from newly qualified nurse to nurse management roles, so as to provide data for a longer term nurse development programme.

The outcomes are directed towards measurable increases in retention, development and satisfaction of newly qualified nurses, more rapid progress to promoted grades and an exemplar for publication and dissemination to other NHS trusts.

Research background

The importance of recruitment and retention of nurses in the context of a national shortage in the NHS, has been recognised for many years. Different factors are involved, but research has shown that low levels of job satisfaction are concentrated in newly qualified nursing staff and that dissatisfaction with career advancement opportunities overall has the largest quantitative effect (e.g. Shields and Ward, 2001).

It is in the interests of patients and members of the care teams, that newly qualified staff learn to meet the needs of the patients and to become integrated within the care teams as rapidly as possible. Thus the research focuses on these nurses, developing it to address their transition to management roles as shortages of staff mean that nurses need to move rapidly towards taking on management responsibilities.

This puts retention in the context of a developmental career programme that can contribute to attracting and retaining staff. Such development is also integral to progression through the common banding structure for jobs within the Service, instigated by the Department of Health's *Agenda for Change* (1999 et seq).

The research described in this report has been developed from the Learning in Nursing, Accountancy and Engineering (LiNEA) Project. This project was well grounded, funded research within a prestigious, multiprofessional, national research programme, commissioned by the Economic and Social Research Council (ESRC) and awarded to Sussex and Brighton Universities, 2001 – 2005, in partnership with employers. Its focus was early career learning and support.

The LiNEA research was based upon the actual experiences of new nurses, in their ward settings, so as to discover their learning needs and the challenges they perceived. While research into such workplace learning has been surprisingly neglected in the past, it is now becoming recognised as essential to the understanding of professional development. This is evidenced in the funding of the LiNEA Project as part of the major ESRC's Teaching and Learning Research Programme, which has a significant focus on

generating and disseminating research relevant to employers/users and which has wide generalisability. The research benefited from both the theoretical basis of research in this Programme and its national profile.

The employers collaborating in the Nursing sector were Trusts in the South East of England, amongst whom were the former Brighton Health Care and Mid Downs Trusts, now Brighton and Sussex University Hospitals NHS Trust.

There was agreement with Trust partners from the start to collaborate with the Universities in considering implementation of the research outcomes, which would then be evaluated as part of the research.

The LiNEA research involved:

1. Observation and interviews of 40 newly qualified nurses at work in the wards and interviews with their managers and preceptors/mentors were carried out. There were four workplace visits over a three-year period. (The same pattern of visits was undertaken in the engineering and accountancy sectors).
2. The visits during the first 2 years of the newly qualified nurses' employment led to an Interim Report, which was sent to our partner NHS Trusts for discussion. The Report recommended areas where support for novices could be improved and the Project team offered to evaluate any changes in such learning support systems that a Trust wanted to take forward as action research.
3. Implementation of these research findings by BSUH Trust staff across the three hospitals during the following year was constructive and fruitful. They set up a LiNEA Steering Group that created six initiatives to support and develop newly qualified nurses (NQNs) in the 'massive' change from being a student to a qualified nurse.
4. The effects of the initiatives on a pilot sample of NQNs were then evaluated as part of the LiNEA research in an Action Research stage of the project, in collaboration with employers, building on the findings of the fieldwork. This stage involved visiting a new sample of novices who were going through the changes resulting from the action research.
5. This pilot evaluation of the Trust Steering Group's initiatives showed positive outcomes which needed to be followed up with a bigger sample.

The Steering Group also saw the potential for a longer-term programme of support and development for nurses, from newly qualified status towards more responsibility for ward management (progression from D-E-F-G grades, now part of the banding system). They wished to take this forward beyond the end date of the LiNEA Project in June 2005. The University of Brighton LiNEA researchers, in collaboration with the Trust Steering Group, put in a successful research proposal for a Brighton and Sussex University Hospitals and Medical School Research and Development Grant for 2005-2006. This used the main methods that had been tried and tested during the LiNEA Project – and was named the LiNEA-R project, with the 'R' signifying the purpose of enhancing retention of nurses.

The Trust's six initiatives for newly qualified nurses (NQNs) were centred around supporting the areas of learning found to be challenging for the NQNs and assisting their mentors. This was done by means of:

1. A 'Trust Day' for final year students: 'The Nurse as a Professional Practitioner: Preparation for Role Transition' to introduce the Trust and give examples of role progression.
2. A 'Nurturing the Novice Day' for mentors of NQNs about areas problematic to NQNs such as prioritising and delegating.
3. An 'Induction Day' for NQNs to discuss challenges and opportunities for training and development.
4. The development of Competencies was devised to clarify what their managers expected of newly qualified nurses when they started work and to give them a set of targets to aim for.
5. The development of 'Action Learning Sets' was devised to provide structured discussion sessions with peers, away from the ward, with an experienced nurse as facilitator.
6. The development of a 'Rotational Programme' for NQNs to gain a range of experience for NQNs in three 6 month placements in different nursing specialities.

LiNEA-R's aims were to:

- Evaluate whether the Trust's six learning and support initiatives for newly qualified nurses were effectively enhancing nurses' development across the three hospitals, and feeding back results so that they could be acted on rapidly.
- Research into nurses' experiences in progressing from D to E grade, and the E to F and F to G grade transitions, to provide evidence of the learning development of nurses into ward manager posts and thereby assist the Trust's LiNEA Steering Group to assess how learning support could be focussed most effectively.
- Write up the total career support and development programme, in collaboration with the Steering Group, so that it was fully evidence based and could be published and disseminated.

METHODS

The methods included a survey, interviews and observation of samples of nurses, from newly qualified to senior grades, mentors, ward managers and senior managers.

1. **A survey** of newly qualified nurses (NQNs) was carried out across the Trust hospitals in collaboration with the HR personnel who were part of the LiNEA-R Steering Group. The survey provided base line information that targeted the NQNs at the start of their career. 25 NQNs completed the survey.
2. **Systematic follow-up of pairs of mentors and NQNs** pursuing the learning support initiatives set up by the Trust was undertaken. This aimed to interview NQNs and their mentor, so that every pair of mentors and NQNs had attended the relevant training days and undertook to follow through the LiNEA recommendations. The pairs were interviewed separately to see whether the learning experiences of the NQNs had been facilitated by the initiatives. 28 NQNs and 10 mentors were interviewed, including the sample obtained from the LiNEA Action Research phase of the study.
3. **Rotational Programme** Two NQNs were interviewed during their first 3-6 months, i.e. on their first placement, and one NQN at the beginning of her second placement. Two mentors of the NQNs on the Rotational Programme were also interviewed.

4. **Data about the learning needs of nurses progressing into management positions.** This involved interviewing and observing in practice senior nurses who were moving from E to F grade. We also interviewed ward managers (H and G grades), modern matrons, care centre managers and general managers about their roles in relation to supporting and developing senior nursing staff. The sample was taken from the Medical and Surgical Directorates across the Trust's hospitals.

<u>Sample</u>	
Senior Managers	10
Ward Managers	11
F grades	12
E grades	9
NQNs	28
Mentors	10
Total	80

Of the 21 E to F and F to G grade nurses, 19 were also shadowed for half a shift. This was to observe the nature of their roles and to triangulate the data from the interviews.

The data were analysed using the qualitative analysis package NVivo. Interviews were tape recorded, transcribed and coded into categories that reflected the learning experiences and stages of the nurses' learning. Learning needs were derived from this data.

Multi- centre Research Ethics Committee (MREC) ethical approval had already been gained for the LiNEA Project. As the methods were the same in the development of the research, approval was given for a new sample of nurses as an addition to the original proposal. Data were anonymised, given a code name and stored securely. Participants were assured that no-one would be identified in reporting the findings.

The **findings** of the research are reported in sections that focus on: Newly Qualified nurses, Senior Nurses and Ward Managers. Suggested 'Action Points' are given for each section.

II.

NEWLY QUALIFIED NURSES

Survey results showed that the 'typical' NQN who chose to work for the Trust was female, aged between 21-30, single, with no children, of white, British origin, was bursary funded, trained locally to receive a Diploma in adult nursing and worked full time in either a medical or surgical ward. Reasons given for choosing the Trust were: they had trained locally; wanted to continue living locally; had been seconded by the Trust initially; the Trust's good reputation for training and development and its links to local universities; and wanted to broaden their knowledge and interest in nursing. The survey identified NQNs so that, with their agreement, they could be followed up in the research. It also contributed as a start in enabling the Trust to begin a data base of NQNs to target their support and development.

ACTION POINTS

- HR need to collect demographic data of all NQNs who start work for the Trust so as to establish an accurate database of NQNs
- A rolling programme of surveys/interviews is needed to elicit the views and experiences of NQNs so that support can be targeted and progress monitored.

Evaluation of the Trust's six initiatives

It was clear that most of the initiatives had a positive effect on the experiences of NQN's. However, there still remained a lot of work to be done in relation to ensuring that both mentors and NQNs were given time to implement these initiatives.

1. Trust Day: 'The Nurse as a Professional Practitioner: Preparation for Role Transition'

This event for final year student nurses was valued by them because it described how they could develop their careers in nursing and gave advice on how to gain general experience at the outset. Opportunities to hear about support services for patients were also seen as useful. The picture given of lack of vacancies however was gloomy.

ACTION POINTS

- Continue to offer this initiative because final year students have found it to be beneficial
- Focus the Day on the Trust and what it has to offer both patients and staff
- In the current climate, explain about limited job opportunities in a positive way, for example, describing the work that is being done to develop more opportunities for staff to progress up through banding, thus increasing job opportunities in the lower bands.

2. 'Nurturing the Novice Day'

This was a day for mentors with the aim of introducing them to the findings of the LiNEA Project and to teaching specific skills found problematic for NQNs (e.g. prioritising, delegating).

In general, the mentors now recognised the importance of ensuring that NQNs had time to discuss their progress. Whereas before time was not found to go through NQNs' learning needs, some mentors now ensured that time was set aside to enable this to happen, such as half an hour a month.

Mentors who had been on the 'Nurturing the Novice Day' had recognised when an NQN had a 'crisis of confidence' at four months as this was a finding of the main LiNEA Project. As a result, they supported her through this.

Overall, mentors now recognised the importance of feedback and praise. However, feedback tended to be unstructured, informal and 'hit and miss' in frequency, with negative consequences for development and confidence of NQNs.

The Day was not taken as seriously by mentors who were not yet formally certificated as mentors, even though they were acting as such and had taken the training.

In a number of cases, mentors and NQNs were not being matched. Mentors had either not attended the relevant training days, with some poor mentoring experiences being evidenced, or were attending the Nurturing the Novice day but not being matched to NQNs.

Some mentors only worked with their NQN infrequently and nights and week-ends were particularly likely to leave NQNs unmentored.

Mentorship

A number of general issues were raised about mentorship by NQNs' mentors:

Mentorship training: A number of the mentors had not undergone any formal training and thought that attendance at an annual update was all that was necessary to mentor both students and NQNs. It is a mandatory requirement from the Nursing and Midwifery Council (NMC) that all mentors attend a recognised course, an annual update. The NMC (2006) has named those who provide support for NQNs as 'preceptors' and recognise that whilst there are no formal qualifications associated with being a preceptor, individuals will need preparation for the role. The NMC also strongly recommends that NQNs have a period of structured support on beginning employment and regular meetings with a preceptor.

Difficulties were faced by those wishing to train as mentors in getting release from wards or departments and sometimes they were not made aware of training opportunities by senior colleagues. They needed to be proactive in identifying their training needs.

Barriers to effective mentorship: Lack of time was the main barrier, especially when most mentors were senior nurses in charge of a ward or juniors who had little experience of mentoring. If the mentor was experienced and trained they tended to be overloaded with students as well as NQNs. Sharing learners with helpful others and giving students days in other departments helped. Effective teaching in clinical practice needed time to organise, research, prepare and deliver; most teaching was done on an ad hoc basis or was not as structured as it could be for maximum effectiveness. Not working with mentees could happen when shifts were arranged with other agendas in mind. There needed to be a better understanding of the labour of mentorship from all the team and the time needed to do it.

Improving the Role of Mentorship in Clinical Practice: There was a need to increase time for the orientation programme, as most of this time (usually two weeks supernumerary) was spent visiting other associated wards, departments and specialist colleagues, rather than in the environment in which they were to be staff nurses for the first time. Time for mentor and mentee to meet was needed to be structured in a manner that prevented interruptions, such as having the nurse in charge take care of patients during their meeting.

Support for Mentorship: Most mentors identified the need for structured support for themselves for their own development. They rarely had opportunities to discuss their mentor performance with others which could affect their confidence in supporting NQNs.

ACTION POINTS

In relation to **NQNs**, there is a need:

- To continue to offer this initiative as it is essential for providing positive experiences for NQNs

- To ensure all NQNs are allocated to a mentor who has attended the Nurturing the Novice Day
- For NQNs to be self motivated and take responsibility for their own continued learning opportunities.

In relation to **mentors**, there is a need:

- For all mentors of NQNs to attend the 'Nurturing the Novice Day', owing to the positive effect it has had on those who have attended
- To ensure all mentors are aware of the importance of structured, regular constructive feedback for the progression of NQNs
- That all mentors who provide support by means of teaching and assessing the competencies of all NQNs and students in clinical practice, must have attended a recognised NMC mentor preparation accredited course
- To provide structured support mechanisms for all mentors i.e. protected time and strategic planning by the organisation
- For mentors to recognise that NQNs should not be expected to take on full case loads from day one

In relation to **clinical environments** there is a need:

- To map the 'off duty' of NQNs with that of their mentors so that NQNs work with mentors as much as possible, including making certain that mentor support is fully available at night and during weekends
- To ensure that not only is collegiate support available when the demands of the clinical environments are reduced, but also to recognise that NQNs need more support in line with pressures resulting from the increased needs of patients
- To identify specific individuals who want to be qualified mentors, rather than them feeling 'forced', as motivated enthusiastic mentors equal good mentors
- For NQNs to only be allocated mentors who fully understand the need for structured and constructive feedback and the consequence of this on an individual's performance.
- To have strategies in place to support NQNs in the absence of their mentor
- To make use of staff appraisal systems to offer regular structured feedback to both NQNs and more experienced colleagues

In relation to **NHS trusts**, there is a need:

- To enforce mandatory attendance at annual mentor updates for qualified mentors as stated by the NMC (2006)
- To ensure all 'preceptors' of NQNs have attended at least a mentor preparation programme, in line with NMC guidelines (NMC 2006)
- To develop a more collegiate approach to mentorship so that 'helpful others' within the multi-disciplinary support the 'preceptors' of NQNs
- To develop a strategy to provide a mechanism for structured feedback for both mentor and mentee
- To respect the supernumerary status of all NQNs and to ensure that all clinical environments view the induction process for NQNs as building upon that which is already in place for students. It seems that not all NQNs are given the required induction when they obtain a post in a clinical area in which they have been a student as it is assumed their existing knowledge of the area is sufficient. There therefore needs to be an additional level of induction to any given clinical area: an induction that focuses on expectations of NQNs, their accountability and responsibilities and the support nurse(s) available to them.

- To make mentorship opportunities explicit for all
- To develop Action Learning Sets/clinical supervision for more senior mentors and all staff for future staff development and succession planning
- For mentors not be in charge of a shift, or if they are, they should not be allocated a patient caseload, in order that they are available to provide support to the team, as well as the NQNs
- For strategies to be in place to provide structured cover for protected time so that mentors can effectively support, teach and assess their learner's or learners' progress and competence in clinical practice
- To recognise the strain and personal 'labour' that goes into mentoring
- To develop strategies to deal with the current perceived lack of training opportunities due to financial constraints within the NHS

3. NQN Induction Day

This Day was appreciated by NQNs because of: the welcome of the Chief Executive; reassurance about anxieties already experienced; networking with other NQNs; opportunities to reflect on and find solutions to challenges in practice; and receiving the competencies booklet. Those having negative experiences could dominate discussion though, and a paediatric nurse found it too focussed on adult nursing. For some, the Day needed to be earlier on in their post for them to benefit. Some NQNs did not know about the day or found out about it too late or could not be spared from the clinical area.

ACTION POINTS

- Continue to offer this initiative because of the positive comments from NQNs
- For the Induction Day to facilitate discussion of both positive and negative experiences, of NQNs, rather than focussing on those with grievances
- The Induction Day should ideally be attended in the early days of an NQN's post so as to enable a more balanced view of experiences e.g. within at least the first 3 months and before they reach the 'crisis of confidence' stage (LiNEA Project)
- The Induction Day should be followed up after, for example 6 months, with another day to see how NQNs are progressing
- The content of the Induction Day should target all branches of nursing so as to reduce the adult bias of the current programme
- Reflection needs to be facilitated for NQNs' experiences in order that they might find solutions to problems that may have arisen since they started their post.

4. Competencies

Statements of competencies were viewed by the NQNs as extremely valuable in developing confidence and a sense of achievement. However, there was still evidence (as found in the LiNEA results) that NQNs did not see the point of working on competencies if they were never looked at or signed by the mentor. There were difficulties in mentors spending the necessary time and lack of information about the purpose of the competency booklet. Competencies appeared to work best when they were either specific to the area of nursing, or were being used along side a Work Based Learning programme (Structured learning on the job) in which mentors familiar with the competencies had been assigned to NQNs.

ACTION POINTS

- NQNs should have regular feedback on completing their competencies to ensure that they are progressing, thus increasing the confidence of NQNs
- Allow time to provide formal feedback on competencies
- For NQNs to have the standard Trust competencies to achieve, as well as competences specific to their own clinical area
- Ensure NQNs can see the value attached to obtaining competencies by making them relevant to their clinical area
- Provide protected time for mentors to assess competencies in practice
- Ensure that all mentors know how to manage the process by which the NQNs obtain their competencies i.e. assessment process and giving feedback
- Ensure that mentors are provided with protected time to teach, provide constructive feedback and support NQNs to obtain their competencies

5. Action Learning Sets

Action Learning Sets were set up to give the NQNs a forum in which to discuss practice issues. NQNs were reassured by seeing that they shared challenges with other NQNs.

Although senior management were listening to their issues by valuing their contributions and suggestions for changes in practice, there could be lack of follow up in relation to issues raised. This raised questions of whether there was a need for better clarification of the purpose, function and limits of Action Learning Sets, the responsibility of those involved in them and requirement for further training and support for facilitators in dealing with such issues around making changes.

For those who had a positive experience, the Action Learning Set was a time for them to see how fortunate they were to be working within a supportive environment, rather than an environment that left them to their own devices.

Some NQNs were unaware of the Action Learning Sets or did not understand what they were, so had not accessed them.

ACTION POINTS

- Continue to offer this initiative, as it has been valuable for those who have been able to attend
- Clarify what Action Learning Sets are and their purpose
- Training for facilitators of Action Learning Sets
- Ensure that NQNs are given prior notice of the availability of Action Learning Sets
- Provide strategies to allow NQNs to leave the clinical environment so they can attend Action Learning Sets during ward time and not their own
- For the Action Learning Set facilitator to follow up issues which are raised during such Sets

6. Rotational posts

The Trust introduced a Rotational posts programme to develop clinically skilled, experienced and flexible practitioners who, at the end of their Programme, would be sufficiently competent and confident to take on a more senior role within the workforce.

Selection for the Rotational Programme seemed to create a sense of value and self worth amongst successful NQNs. As with the original LiNEA research, support was pivotal in assisting the transition and career development of the Rotational Programme NQNs. The processes that facilitate their progress were:

A structured induction programme: consisting of visiting areas linked to the ward and spending time with allied professionals

Education about their area of work: going through common conditions of the patient group they were caring for, being shown related Anatomy and Physiology e.g. on a model and understanding the rationale behind nursing care for various conditions

Being orientated to the area in which they were working: especially if they were new to the Trust

Support from a mentor and the nursing team: was seen by NQNs as essential

Being supervised and assessed clinically in practice

Receiving regular, constructive feedback about their capabilities.

Overall, the Rotational Programme received a positive evaluation from all 3 NQNs. Participation in the Programme seemed to ensure the continuation of the learning and training process after qualification, as well as the enhancement of, and/or gaining of competencies. It provided a clearly defined structure for professional development in the initial period of work. One of its major benefits was to instil in its participants an appreciation of the importance of continued lifelong learning and that training is not something that comes to an abrupt end upon qualifying.

The Rotational Programme was the subject of a separate report by the research team for the Steering Group entitled 'LiNEA Evaluation of the BSUH Pilot Rotational Programme' August 2006. Fuller evidence for the Action Points below may be found in that report.

ACTION POINTS

In relation to **mentor preparation:**

- Ensure mentors who are allocated to Rotational Post NQNs, are qualified (i.e. they have attended an NMC recognised mentor preparation module) or are supported by a qualified mentor
- Develop an in-house support programme to ensure mentors understand the paperwork and what is expected of them in their role as mentor to Rotational NQNs
- Ensure mentors who have attended the 'Nurturing the Novice Day' are matched to the NQNs, as only 1 mentor seemed to have been on this day
- Allocate mentors in terms of seniority i.e. senior band 5 or junior band 6, as the more experienced nurse appeared to manage their time more effectively in order to mentor. Allocating more than 1 mentor with different levels of seniority would help to ensure adequate support for the NQN. However this needs to be done by ensuring each mentor has clearly defined responsibilities to avoid the 'I thought she was doing it' problem
- Having only 1 mentor working part-time has implications for supporting NQNs, they need either 1 full time mentor or more than 1 part-time mentor, but again with clear discussion about sharing responsibilities
- There needs to be a clarification of the expectations of the NQNs and the expectations of the mentors at the start of each placement to avoid unrealistic expectations of both NQN and mentor.

In relation to **feedback:**

- As with students, the NQNs would benefit from having an initial interview, a mid-term interview and a final interview with their ward manager and mentor to assess progress through the Programme
- Feedback needs to be given at each interview, which should be constructive and concentrate on the NQN's skills, knowledge and competence rather than 'Yeah you're fine'
- Giving constructive feedback to mentors in practice could reassure them that their efforts are noted and help them feel valued.

In relation to **assessment and competencies:**

- Responsibility for completing the competencies needs to be clarified, is it just the NQN's responsibility or the mentor's too?
- Competencies need to be discussed at the 3 interview points. There also needs to be clarification of who checks that competencies have been completed
- An action plan needs to be set up if NQNs are having difficulty with being assessed – so if their mentor is not around or there is no time – there need to be clear guidelines for them to achieve their competencies
- A nurse educator to cover the wards taking part in the rotation would be the ideal –to work with NQNs, encourage them to question their practice and help assess their competencies.

In relation to **managing the transition to the second and third placements:**

- Expectations from new staff are higher because they are not NQNs any more – but they are still moving to a new area and so the transition needs managing
- There needs to be some form of induction to the second and third placements. This could possibly be a supernumerary shift or part shift
- An introductory booklet or welcome pack to the next placement before they get there would be helpful so they have time to prepare themselves for moving. An informal visit to that area beforehand to meet the ward manager and their mentor would be an advantage
- Have handover meetings to support the developmental focus of the Rotational Programme, e.g. between the ward managers involved in the Rotation; the NQN and the NQN's 1st placement mentor to 2nd placement mentor and then between the NQN and the NQN's 2nd placement mentor to 3rd placement mentor, to enhance the transition phases
- Put in strategies to help the ward teams manage the loss of a valued team member at the end of 6 months.

In relation to **support:**

- The time spent waiting for the NQN's PIN number to come through from the NMC must be structured in a way that the golden opportunities for learning the role of a staff nurse are not lost in performing only care assistant duties. Supernumerary status should commence once the PIN number is through
- The multi-disciplinary team need to recognise that NQNs do not always feel confident to ask for help when required. Therefore it would be beneficial for them to offer regular support even if the NQN has not asked for it
- The Non-Rotational NQNs need to be supported in a way which complements that received by Rotational NQNs (assuming that not all NQNs will be offered or will take up the offer of the Rotational Programme). This parity may mitigate the current perception that Rotational NQNs receive more support

In relation to **further evaluation**:

- As this was an evaluation of a pilot project, and focused on the experiences of a small group of NQNs, there is a need for a continued rolling programme of evaluation of the Rotational Programme. We recommend that Rotational NQNs be interviewed once they have completed the Programme, so as to gain a more rounded view of their experiences, and that this process continues thereafter with any subsequent Rotational Programmes started by the Trust.

III.

SENIOR NURSES

What Es and Fs Enjoyed about their role

The most enjoyable aspect of the E and F grade roles was caring for their patients. Providing a consistently high standard of care was also important, as was being able to do their jobs properly, to the best of their ability. Working within a team and interacting with colleagues, the variety of their work and the adrenaline buzz it gave them when the ward was busy were also satisfying. Supervising, supporting and developing colleagues, making a difference to their patients and being respected by others and consulted in patient care were also factors in maintaining enthusiasm for their roles.

Role and responsibilities of an E grade

The E grades discussed their role in terms of 5 main categories:

Clinical: managing patient care, maintaining a safe environment for patients and staff, recognising changes in patients' conditions, dealing with difficult situations, performing link nurse duties and keeping up to date;

Managerial: coordinating the ward or a side of the ward;

Interpersonal: communicating information to staff and the multi disciplinary team, being an advocate for patients and staff;

Supportive: supervising and overseeing junior members of staff;

Educational: mentoring and teaching juniors.

Role and Responsibilities of an F grade

The F grades discussed their role and responsibilities in terms of 8 main categories, with development of the E grade role embracing setting quality standards, personnel issues and deputising for the ward manager:

Clinical: leading the team as a clinical expert;

Quality: setting standards and following Trust policies and procedures;

Managerial: coordinating the ward and performing extended roles;

Interpersonal: communicating information to staff and other professionals, being an advocate for patients, dealing with complaints and conflict;
Supportive: supervising staff and colleagues, mediating between the ward manager and staff, an information giver and resource;
Educational: teaching, mentoring and developing junior staff, assessing staff, being used as a resource about available development opportunities;
Personnel: human resource issues such as appraisals, sickness records; off duty, manpower
Deputising for the ward manager.

There was a noticeable variation in the number and type of responsibilities that the F grades had; some were only responsible for running a shift when they were on duty, whereas others did the off duty, performed appraisals and were involved in capability procedures. Some also took patients when they were in charge, whereas others were supernumerary and acted more as a resource to the staff.

Challenges of the E and F grade roles

The challenges of the roles related to maintaining standards of care whilst working under pressures of time and competing needs; getting through the day; having enough staff to manage the workload and maintain a safe environment, juggling patient care and the day to day management of the ward, re-prioritising on the hoof, trying to concentrate on patient care as opposed to patient throughput; managing people, situations and stress; having the time to mentor and teach juniors, to assess them in practice and give feedback, to support juniors and colleagues; dealing with the changing role of the nurse; encouraging others to be proactive; having sufficient support from medical teams; keeping themselves updated; managing personnel issues; and coping with the after-effects of reconfiguration, such as merging teams.

The challenges all appeared to relate to reacting to the current situation nurses found themselves in. Thus the response was often stressed, ad hoc, pressured and rushed. There seemed to be little time for a measured, objective, even proactive response for dealing with situations. The workload was increasing, as was the pressure to perform. In some cases, the senior grades spoke about being in a constant state of stress, concerned about their accountability whilst looking after patients and taking charge of the ward. The pressure was constant and they had no let up or time to think and reflect on what they were doing.

Success as seen by E and F grades

The E and F grades equated success with experience, knowledge, efficiency, competency, confidence and honesty. To be successful a senior needed to be a good team worker and leader and credible in practice. Being professional, approachable, caring and an excellent communicator were also important. Success was also about maintaining standards of care, commanding respect by getting involved in patient care, supporting colleagues, challenging practice and behaviour, enabling others, managing conflict, troubleshooting clinical situations, actively listening to others, and having a strong sense of self. Success as a leader was associated with someone who was capable of supporting and deputising for their ward manager, instilling discipline and authority on the ward, supporting the team, who was confident in their decision making and able to justifying their actions, objective and fair, decisive and clear with staff, professional, honest, an excellent people person, who was able to lead the team by example and act as a role model, who knew the team, individually and collectively, who

was able to create a happy, relaxed team, and deal effectively with stress, someone who kept updated, mediated between the ward manager and the team and was also able to meet trust targets.

How were they learning?

The E and F grades learnt aspects of their roles through a mixture of informal and formal learning, although the majority of knowledge and skills were learnt on an informal basis.

Managing patient care and being a clinical expert were mainly learnt through experience, practice, demonstration by and supervision of a senior, asking questions, learning from role models, studying and attending courses or study days. Courses related to updating mandatory skills and developing clinical skills and knowledge e.g. specialist nursing courses like HDU, cardiac, or extending skills such as venepuncture and cannulation.

Maintaining and setting standards were learnt by taking a lead in project work i.e. the Essence of Care work; from role models and from F grade away days.

Managing the ward, team leading and coordinating were learnt mainly through observing seniors at work and drawing on their expertise, demonstration by and supervision of a senior, asking questions, talking to peers, learning from role models, shadowing a senior, trial and error, picking it up as they went along, practice, experience, secondment opportunities, reflection, and attending courses such as LEO (Leading an Empowered Organisation). LEO was seen as useful for making seniors more aware of their own leadership styles, but not very practical in terms of dealing with the day to day issues those seniors face, such as writing the off duty or dealing with Personnel issues. The main criticism was that LEO did not enable seniors to change practice once they were back on the wards. The lack of follow through once seniors had attended meant it was very difficult for them to change anything.

Communication was learnt through experience, practice and from role models, trial and error, picking it up as they went along, reflection and establishing relationships with staff over time. Very few had attended people management study days to inform their practice.

Personnel issues were learnt through exposure to them and discussion with their ward manager. A few had attended study days on interviewing and appraisals and one had been to an in-house course on finance. Trial and error was the norm with Personnel issues, so learning how to deal with them as and when they occurred.

Supervising and supporting others were learnt through experience, practice, and reflection mainly, as well as discussing issues with peers and colleagues. Role models and watching others communicate were also cited, as was acting up into the next grade.

Teaching and mentoring were learnt through studying and reflecting on their own experiences as students.

Deputising for the ward manager was learnt from role models, having the opportunity to shadow their ward manager, acting up under the supervision of a senior, attending management meetings with or on behalf of their ward manager and attending leadership skills courses such as LEO.

Support for E and F grades to manage their roles

Support to manage their responsibilities and meet the challenges of their roles, came mainly from their colleagues, peers and ward manager. The number of F grades per ward varied from 1 to 7, which affected how supported the F grades felt. Those areas where more than one F grade was working at any one time, were felt to be more supportive, since Fs felt the benefit of working with experienced colleagues as they were able to draw on their breadth of knowledge and skill if required. The Fs who worked part time found it difficult to meet up with their senior colleagues to discuss ward issues because they usually worked opposite shifts.

Ward managers were perceived as being most supportive if they treated staff well, got directly involved with patient care and led by example. Other sources of support were F grade away days and talking to specialist nurses. Only 1 E grade had attended a clinical supervision session and there was confusion amongst some seniors as to its purpose and benefit. Senior management above ward manager level were not seen as supportive. The general feeling was that senior managers were not visible enough on the wards and so were 'faceless' to the staff. Seniors implied that senior management did not actively listen to them and did not acknowledge the pressures that staff worked under. Conflict within the team as a result of reconfiguration was also an issue, since the tension this caused often militated against support.

ACTION POINTS

- There needs to be more open and honest communication between senior management and ward staff, so actively listening to each other
- There needs to be more contact between senior management and ward staff, so that senior managers have a visible presence on wards
- There needs to be more awareness of the stresses involved in merging teams and more practical support for staff in achieving this.

Support for Professional Development

E grades:

Only 1, out of 9 E grade nurses, had a mentor with whom to discuss developmental issues. The other eight said they could talk to colleagues or ward managers and were not sure how useful a mentor would be. Only 2 received feedback about their capabilities, from their ward manager. Appraisals had been introduced in the previous year for two E grades and had been running for many years in the wards of another two; appraisals had not been given for those in other wards. There were differences in views about whether appraisals should address the individual's capabilities and development needs or whether it was generally about further study and training. E grades felt that they had to be proactive about their development and seek learning opportunities rather than relying on any direction from seniors.

F Grades:

None of the F grades mentioned having a mentor, although one said she would have liked one when she became an F grade. There was also the question of who was in the best position to provide feedback to seniors if they rarely worked with other seniors. The transition into the F grade role was largely unsupported by an adequate induction period. The F grades felt confident clinically but their managerial knowledge and skills were often

assumed. The Fs, who were supported professionally, had been enabled to develop themselves gradually over time with support and guidance from their ward manager and other seniors on the ward. They needed to be proactive and seek out their own learning opportunities; they could not necessarily rely on a senior to do it for them. There was also the issue of the Trust being able to facilitate the development of senior F grades, since once they had reached a certain level of seniority, the only avenues open to them seemed to be a ward manager or a specialist role. There seemed to be no knowledge of how the Trust was encouraging seniors to stay on the wards and maintain their expertise.

ACTION POINTS

- For senior staff to have a yearly appraisal
- For senior staff to have regular, constructive feedback about their performance
- The purpose of appraisals needs to be clarified, so that staff know exactly what should be discussed
- There is a need to clarify who is in the best position to appraise seniors
- There is a need for seniors to work with a more experienced colleague on occasions, so as to receive feedback on their performance and enable them to improve their practice
- For senior management to develop a structured induction programme of support for those in transition, so from E to F (senior band 5 to band 6) and F to G (band 6 to band 7), ideally with a mentor, and a period of supernumerary status so as to shadow a senior and learn more about the role
- The Trust to encourage a culture whereby seniors are proactive themselves and seek out learning opportunities
- For ward managers and senior management to make explicit the learning opportunities the Trust can offer seniors in terms of progressing in their careers
- For senior management to devise strategies to encourage senior staff to stay at ward level but still develop their knowledge and skills, so as to pass on their expertise to juniors.

Contextual factors that affected E and F grade professional development

Factors that affected professional development were:

Personal motivation, being proactive and taking responsibility for developing oneself;

Family circumstances, having the time and energy to commit to a course, for example, when the Es and Fs had young children at home and/or worked part time;

Staffing levels on the ward being poor so as limit access to study time;

Being unable to study in ward time owing to inadequate staffing and busyness of the ward;

Encouragement and support from a senior to study;

Location and availability of courses, especially mandatory days which were often oversubscribed;

Current financial status of the Trust since staff education was not seen as a priority;

Access to study leave which varied from ward to ward and also in terms of funding and time allowed to study;

Lack of a structured teaching programme for all staff on the wards;

Logistical difficulties in accessing information for example, being able to contact the IT department for a computer password.

Attending E and F grade away days was also another factor. Only 3 E grades had attended an away day, but all 12 of the F grades had been to one or more F away day.

The away days were perceived as useful, but attendance was becoming more difficult because of poor staffing levels on the wards. F grades felt that the nature of the away days had also changed to concentrate more on performance targets and Essence of Care issues, as opposed to everyday clinical and managerial issues that they faced and wanted to change.

E and F grade development programmes access: three E grades had heard of such a programme but none had attended. 11 of the Fs were not aware of a designated F grade development programme. One F said she had attended one day on such a programme but this 'fizzled out' after that session.

Part-time working: of the 21 E and F grades, 8 worked part-time and this was mainly because they had a young family. Those who worked part-time often had fewer responsibilities at work, which seemed to be because they had different shift patterns and worked different hours from their full time colleagues. Part-time workers often felt less involved and up to date with current ward issues which made them feel isolated at times. Working part time also had implications for establishing relationships with medical colleagues and other professionals. The overall impression was that part-time workers had come to expect less than their full-time colleagues in terms of professional development. Full-time work was perceived as equating with showing a commitment to the ward, whereas if a nurse worked part-time, it was perceived that their commitment was to their family and not the ward, and indeed the majority of part-time workers had put their career development on hold until their children were older. But on the whole, the part-time workers were satisfied with their professional development. They felt that they had been afforded opportunities to develop if they had wanted to, and their ward managers had been flexible and supportive of them in doing so.

ACTION POINTS

- For ward managers to continue to be supportive towards part-time staff in terms of offering flexible working hours and shift patterns
- For ward managers to keep part-time and full-time staff interested in their work, by being aware of their capabilities and offering new responsibilities
- For senior management to be honest and open about why training courses or funding has been withdrawn
- For the Trust to have a consistent approach to study leave and funding
- For senior management to oversee staff training records so that an accurate data base is maintained
- Standardising what courses or study days are available to seniors, so for example, if E grade away days do run, then ensuring that all E grades are invited and keeping records of attendance.
- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that career progression is less fragmented and seen as more of a natural process.

Career Motivation and Intentions

E grades: Of the 9 E grades, 4 envisaged moving into ward-based F grade roles. Three preferred to stay as senior E grades because they wanted to maintain direct patient contact. One of these had been a G grade previously and had no wish to return to the role. Two E grades had recently been approached by their ward managers and asked to act up as F grades for a period of time, which they were looking forward to. Two felt that moving into a ward-based F role would take them away from direct patient care. They also felt it would be very stressful. They preferred to move laterally into education or practice nursing, so they could maintain a degree of patient contact, keep on using their

skills and knowledge and move into F grade positions that they considered were less stressful.

F grades: Of the 12 F grades, only 2 said that they could see themselves as moving into a ward manager position. It was not a question of capability, as the Fs felt they could do the job, it was more a question of whether they would be happy in a G grade role and whether it was really what they wanted. The Fs felt that as a G grade, their clinical input would be limited and the focus on business management was not attractive. They also perceived the role to be isolating, stressful, mentally exhausting, thankless, and 'more hassle than it was worth'. Four were content to stay as F grades for the moment, as 3 of these considered themselves to be relatively junior, and 1 had been a G grade before and did not want to return to the role. Three Fs had experience of acting up into the ward manager's role. Two were glad to return to being F grades but one found it very hard to settle back into the role and relinquishing the responsibility.

Support from senior management for those who acted up and were then demoted was poor, as was support during the acting up period in general. It was very much left to the individual to find and develop their own support network, as opposed to a structured support network being in place for everyone. Two of the Fs were demotivated and had lost interest in their work. What was the Trust doing to recognise this and encourage senior people with extensive knowledge and experience to stay?

ACTION POINTS

- Senior management need to find ways of making the ward manager role more attractive for staff in order to recruit into the position
- Expectations and responsibilities need to be made more explicit so that staff know what to expect before they go for a ward manager post
- Senior management need to develop an approach to succession planning so that staff see promotion as more of a 'seamless' progression, as opposed to a 'step up' approach
- More input is needed from senior management in terms of developing career pathways for senior staff so that they are aware of the options available to them
- Senior management need to keep their seniors interested in their work, by offering them learning and developmental opportunities. Maybe a secondment programme for seniors or a rotation would be beneficial
- Seniors who act up into ward manager or F grade positions need a structured and supported programme of induction to ease their transition
- Senior management need to provide more visible support for those in senior positions, for example, providing a network of support, attending ward meetings, and being a resource for staff

Support for training and development needs

In terms of support for training and development, Es and Fs would like **role expectations to be more explicit**, from ward level staff up to senior management. They felt that creating more awareness of peoples' roles within the Trust would go some way to building more of a supportive working environment, as would more open and honest communication between ward staff and senior management.

Having more time to spend with senior colleagues was considered beneficial, to update, educate and feed back on certain issues, and having appropriate admin support was important in freeing up seniors' time.

Seniors would also like more staff and more time to deliver patient care, yet they realised that in the current financial climate, support in this sense would be practically impossible to achieve.

Seniors would like **more consistency in the Trust's approach to allocating study leave and funding**, as it varied so much between wards.

They would also like a **ward based structured teaching programme**. Because of the difficulties in actually attending study days, Es and Fs felt that teaching sessions should be more on an ad hoc basis, so in their workplace, maybe during lunch time or during the handover period. Mandatory study sessions could be amalgamated so as to limit the time that staff spent away from the ward.

Es and Fs would like **teaching on human resources**, such as capability and disciplinary procedures; 'tips of the trade' type sessions on for example, how to write an off duty or coordinate the ward; people management skills, such as conflict resolution; financial planning and budgets; IT knowledge and skills and using them in practice.

Seniors would also like a **structured induction programme** to guide those in role transition, rather than being 'thrown in' and 'left to get on with it', as seemed to have been the case for most. They also thought that a **career development programme within the Trust** from D grade through to G grade, would be of great benefit, in helping staff prepare for the role ahead.

ACTION POINTS

- For senior management to make role expectations and responsibilities more explicit, from ward level staff up to senior management
- For improved communication between ward staff and senior management
- The development of an in-house, rolling teaching programme aimed at all ward staff, and devised and constructed by in-house staff. Sessions could operate on a rotational basis so as to reach as many staff as possible. Responsibility for giving teaching sessions could be shared between ward areas so that for example, staff on one ward could teach for a month before passing on responsibility to another ward in the same division.
- For Trust policies on study leave allocation and funding to be made explicit to ward staff, so that staff know what they are entitled to. Also for senior management to operate a consistent approach to study leave allocation and funding, so that staff feel they are being treated fairly and have the same opportunities for studying on one ward as they would for example, on another. If this is not possible, then the reasons why it is not possible need to be communicated honestly and openly to ward staff.
- For senior management to be consistent in the study days and courses that it offers staff and think of contingency plans to deliver such training when in times of financial hardship. For example how can they provide training when they are over budget? Also for senior management to be honest and tell staff what is possible to achieve and what is not possible. Maybe asking for help from staff as to what they can do would create a sense of unity in trying to solve the problem.
- For awareness of E and F grade away days to be promoted, especially for E grades as their knowledge of such days was patchy. For Es and Fs to have more of an input into the away day structure and agenda, so as to promote ownership of the days. Fs would like the away days to discuss more day to day clinical issues, as opposed to focussing solely on performance targets, so for example, how they could change and improve practices in their ward area. Fs would also

like those who run away days, to follow through issues raised with actions, so that for example, they provide practical support for changing ward practices.

- Senior management need to develop new ways of delivering study sessions so as to limit the time that staff spend away from the ward. For example, ward based, mandatory update sessions during the handover period or amalgamating mandatory training sessions so that 3 updates could be achieved in one day
- For senior management to develop theoretical and practical study sessions on issues relevant to everyday practice such as human resource issues, writing the off duty, coordinating the ward, managing people and conflict, financial planning and budgets, developing IT skills
- Senior management to devise ways to help wards deal with their administrative pressures, so as to free up nurses' time to deliver patient care
- For senior management to help ward managers and their teams to think about how they organise their time and structure their shifts, so they can make changes to improve their working lives. For example, enabling seniors to make time to meet and discuss practice issues together
- For senior management to develop a structured induction programme of support for those in transition, so from E to F (senior band 5 to band 6) and F to G (band 6 to band 7)
- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that career progression is less fragmented and seen as more of a continuous process.

IV.

WARD MANAGERS

The Managers' Perspective on support and development

Expectations of role: there was little guidance on how to operate the ward manager role. While this allowed for flexibility in its interpretation, some managers struggled to find a pattern that satisfied them. Reviewing various possibilities and discussing how others were managing would have been helpful.

Challenges: ward managers were trying to maintain safety standards under pressure of patient numbers and current financial restrictions that constrained staff numbers, making them aware of their limited control as managers in respect of decisions by senior managers. Personnel issues such as staff disputes, bullying and extended sickness were also challenging.

Managing change: while change could be welcomed, constant changes, often at short notice, with lack of consultation and little support were difficult to manage. Reconfiguration could entail merging new and inexperienced teams and dealing with issues of capability. Being clear and consistent about expectations of staff performance and being robust in maintaining these, were seen as essential to manage the changes.

Relationship with senior management: ward managers wanted to see more of their senior managers to improve communication and understand each others' point of view. Decisions made by seniors resulted in actions at ward level which the ward manager was then responsible for but may not have approved. Senior managers who listened were seen as supportive, but ward managers felt there was a lack of positive feedback. Ward managers also felt that they would have more respect for senior management if they

were more honest and upfront with them about the reasons behind some of their actions. There was a perceived blurring of management roles and responsibilities. Ward managers thought they had less authority now but more was expected of them on performance targets. They were saddened by the impersonal relationship with senior managers with the prevalence of communication by email.

Development: most ward managers started their roles without specific training, relying on informal advice from peers and trial and error. They would have liked help on how to read and understand budgets, personnel issues and monitoring sickness rates. Some had subsequently been to training sessions but not others; they gave their staff priority for course attendance. The RCN course on leadership had enabled some to develop support networks. Staff appraisal was patchy or non-existent. Appraisal was seen as focussed on meeting targets and not personal development. Some found support was there if they asked questions; others felt isolated and out on a limb. The G grade away days could be good for networking but sometimes were seen as overly critical and negative. Administrative help would ease workload.

Staff development and succession planning: It was difficult to release staff for training because of financial constraints on ward cover. The 3 days annual training allowance appeared insufficient and even mandatory training was difficult to fulfil. Records of what training had been undertaken were not routinely kept but at least one ward manager was undertaking this. Training up their F grades for the ward manager role was not generally undertaken and some managers were described as keeping their role to themselves. Nor were F grades passing on their knowledge to E grades. There was a need to make the ward manager role more attractive to F grades; some clearly did not want it while others found themselves promoted into the role in a haphazard fashion. Many senior nurses had drifted into ward manager posts without really thinking whether it was the right choice for them or not, which had led to them struggle with the role. There seemed to be a lack of active 'career thinking'.

ACTION POINTS

- Senior managers' expectations of the ward manager's role need to be clarified and made explicit to ward managers
- The nature and purpose of the supervisory role need to be clarified for ward managers and examples given of how the role works in practice
- Senior management need to decide whether it wants its ward managers to be supervisory or not and stick with that decision, and follow that decision through with evaluations of the role and workshops as to how it can be implemented etc
- For senior management to acknowledge the difficult circumstances that ward managers are working in and actively listen to them
- For senior management to involve ward managers more in the decision making processes that occur – so as to promote ownership
- For senior managers to explain more behind their way of thinking – why did they put extra patients on wards and go above ward managers' heads? What were the consequences of that action? What would have happened if they had not done that? Senior management need to make their 'decision trail' more explicit so that staff understand more, only then can they start to understand the pressures that senior management experience
- There needs to be more practical involvement from HR on difficult to manage situations, more hands on and contingency planning teaching
- For a more practical approach towards teaching i.e. in the workplace to be adopted, so as to limit staff having to leave the ward

- Senior management need to provide more practical support for ward managers and their teams who are going through reconfiguration
- Reconfiguration seems to have been reactive and not proactive for example, in the amount of time given for some ward managers to move wards – why is this and are these processes made plain for those involved in them?
- Senior managers need to be more visible on the wards and talk to the staff as opposed to just the ward manager. They need to work on their image so that staff see them as people and not as ‘faceless’
- Senior management need to be available and accessible for senior staff i.e. based on both Trust sites as opposed to one
- Ward managers need to have a yearly appraisal – and senior management need to discuss with the ward managers who the best person is to have the knowledge and credibility to actually perform the appraisal. Who is in the best position to know a ward manager’s capabilities?
- Senior management need to show an interest in ward managers’ professional and personal development and not appear to concentrate solely on whether or not they are achieving performance targets
- A mentorship scheme should be considered for ward managers so that they have a senior person with whom they can discuss professional and personal developmental issues
- Ward managers need to receive regular, constructive feedback about their capabilities
- Those going into ward manager roles need to have an induction period and structured programme of development and support to ease their transition.
- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that skills and knowledge for the next role are learnt gradually and with structured support
- Senior management need to develop new ways of delivering study sessions so as to limit the time that staff spend off the ward. For example, ward based mandatory update sessions during the handover period, or amalgamating mandatory training sessions so that 3 updates could be achieved in one day
- For senior management to devise contingency plans so that in times of financial crisis, staff development does not become a low priority. Staff need to feel that they are valued in such difficult times, even more so than when things are going well
- Senior management need to devise novel approaches to succession planning so as to encourage staff to move on in their careers and enter into ward management positions
- Career thinking and planning ahead needs to start early on in a nurse’s career so as to encourage the gradual learning of skills and knowledge that is required to perform the next role up.

The Senior Managers’ Perspectives on support and development

Senior managers felt that there needed to be **more clarity in terms of what was expected of the ward manager role**, job descriptions lacked focus, and expectations needed matching to appropriate training and development. They mentioned a wide range of expectations from being a clinical expert, acting as a role model for staff, providing a high and consistent standard of care for patients, acting in accordance with Trust policy and following the procedures in place, being an excellent communicator at all levels, being a good leader and motivator of staff, dealing with Personnel issues and managing their budget, to being politically aware.

Succession planning was key to preparing staff for their next roles. However senior managers were aware that development programmes needed to be put in place for succession planning to take more of a priority within the Trust. Four **main areas of training and support** for ward managers were: activity, budgets, workforce/ personnel issues and maintaining quality; understanding roles and systems in the Trust and where to get help; IT skills were also important. Development in these keys areas should ideally start at E grade (senior band 5) level or earlier and develop gradually.

A **standard training package** was needed for G grades on management/Personnel functions and what was expected of them. More emphasis was needed on practical leadership skills than available in current courses.

Support for Ward Managers to aid learning

Senior managers' proposed that the following would all assist ward managers' learning and development:

- a mentor and time to discuss career development,
- regular appraisals
- developing standards to assess ward managers' capabilities
- opportunities to shadow colleagues,
- regular contact with line managers
- facilitated clinical supervision sessions with peers,
- evaluation from a range of colleagues (360 degree),
- protected time for their development .

ACTION POINTS

- A dialogue needs to be established between senior managers and ward managers in order to discuss issues fundamental to their roles and practice. It seems that senior managers are aware of the problems that ward managers face but this is not communicated to ward managers, as they are under the impression that senior managers are 'out of touch'
- There needs to be discussion amongst senior managers as to their expectations of the ward manager's role, which then need to be filtered through to and made explicit for ward managers
- A mentorship scheme should be considered for ward managers so that they have a senior person with whom they can discuss professional and personal developmental issues
- Ward managers need to have a yearly appraisal – and senior management need to discuss with the ward managers who the best person is to have the knowledge and credibility to actually perform the appraisal. Who is in the best position to know a ward manager's capabilities?
- Ward managers need to receive regular, constructive feedback about their capabilities
- Ward managers need to have facilitated clinical supervision sessions with their peers
- Those going into ward manager roles need to have an induction period and structured programme of development and support so as to ease their transition
- Current ward managers need a structured development programme that focuses training on the 4 key areas of activity, finance, workforce and quality

- Senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that skills and knowledge for the next role are learnt gradually and with structured support
- Senior management need to start a dialogue and take a lead in devising novel approaches to succession planning so as to encourage staff to move on in their careers and enter into ward management positions
- Career thinking and planning ahead needs to start early on in a nurse's career so as to encourage the gradual learning of skills and knowledge that is required to perform the next role up
- Ward managers need to be given protected time for their own development, thus sending a message that they are valued by their managers and their contribution to the Trust acknowledged.

V.

CONCLUSIONS

The issues that Trust senior management need to consider in relation to nurse support and development are:

1. Development within a role
2. Succession planning
3. Lack of feedback or support from seniors for senior grades
4. Clinical expertise, leadership skills and management skills

1. Development within a role

The majority of senior nurses in this study, wanted to broaden their depth of knowledge and skills within their current role, as opposed to developing themselves for promotion. The question for senior management within the Trust therefore is how they can as an organisation, facilitate the development of experienced nurses who want to stay at their present level, regardless of their seniority? Some senior Fs felt 'stuck' in their present roles, with the only avenues open to them to become ward managers or move into specialist roles. Feeling 'stuck' led to a degree of disengagement from their work which was often compounded by a change in their level of responsibility or a more general lack of responsibility in their duties. The challenge for senior management is in trying to facilitate senior Fs growth so that they maintain interest and motivation at their present level. This needs to be tackled in parallel with facilitating the development of seniors who do want to progress to the next level i.e. those who want to become ward managers.

One of the major problems is that staff do not want senior roles anymore, because the expectations of what is achievable are higher and stress levels increase dramatically for higher grades. From the data, one way to make ward manager roles more attractive in order to recruit and retain staff is to offer more support, especially, but not only, at the start of the promotion.

Development was not perceived to be a priority within the Trust but was rather experienced as haphazard and ad hoc. There was also no slack in the system to allow for development. Staff did not have the time, sufficient establishment of staff, or the energy to concentrate on development alongside immediate pressures. The current freeze on training courses reinforced the message that their development was not a

priority. There were problems in accessing mandatory training and this therefore raises the question of where responsibility lies if a nurse makes an error and they have not been on the appropriate training course.

2. Succession Planning

Succession planning was seen as key to preparing staff for their next roles, yet there seemed to be no line of communication between senior managers and ward managers that was addressing this issue and a lack of leadership to push this forward in the Trust. Managers at all levels acknowledged and agreed that knowledge and skills need to be imparted at lower grades/bands and not just developed once staff get into the next role, yet there appeared to be no formal structure in place to support that process.

There is an associated lack of career thinking, of not having career trajectories in place for staff. In most cases, staff were not being actively groomed to take on the role and responsibilities of the next grade/band up. This seemed to be because seniors were not consciously passing on their knowledge and skills to juniors; what did occur appeared to happen by chance, almost by osmosis, since they did not have the time or energy to do it properly. However in some ward areas, seniors were perceived to be consciously keeping their knowledge to themselves in what was attributed to be an attempt to maintain their authority and power. The lack of access to certain information made staff feel there were blanks in their knowledge. This affected their understanding of what was going on in the organisation and how things worked and of how their role fitted in with the overall ethos of the Trust.

The lack of knowledge and preparation for senior grades has meant that too many people have been promoted unprepared and some have failed as a consequence. Staff have gone into senior roles without thinking about whether it was really what they wanted to do in the long term. Again this is associated with a lack of career thinking in nursing in general. Career progression was not a seamless process, it was jumpy and fragmented.

3. Feedback and support in higher grade roles

The general feeling amongst senior staff was that they were working in isolation and rarely received feedback or support from senior management. But paradoxically seniors were aware of many of the difficulties that ward managers faced and of their support needs. The lack of open and honest dialogue between the two groups of managers seemed to militate against support.

There appeared to be no formal structure in place for seniors to tap into for career advice. And for the majority of seniors, who often worked alone as the most senior nurse on duty, there was the question of who assessed their competency level and helped them improve their practice?

Support should be a cascade effect in that the G supports the Fs, the Fs support the Es etc., and senior management within the Trust should facilitate this. However the pressures of work have contributed to a reduction in people's ability to contribute to their collective responsibility, perhaps as a form of protection against further stress. How can stress be best managed within the Trust? There is sometimes a cultural resistance in nursing to acknowledging stress formally where nurses feel they must show that they are coping. There is a need to promote self awareness and teach practical ways to handle stress, as well as addressing some of the factors that are causing it. For example, staff felt that more and franker communication with senior managers would help them to understand the reasons for decisions more clearly. This may seem counter intuitive to

some senior managers given the amount that those on the wards are already having to deal with and the difficulty of some decisions being made. Other contributors to reducing stress, such as recreational facilities and space for staff to relax might be one way of showing staff that they are valued.

4. Clinical expertise, leadership skills and management skills

It is assumed that a good nurse who is capable clinically will be a good leader and manager too. Yet there is a difference between leadership skills and management skills. Clinical expertise, leadership skills and management skills do not necessarily develop at the same rates either.

There was a wide interpretation of the ward manager's role, especially in relation to the supervisory role. The ways ward managers led the team and managed the team showed considerable variation, yet the expectation from senior managers was that they would and could do both well. There was a lack of clarity about the range of things that ward managers were expected to do. No one mentioned guidelines as to what the supervisory role entails. There was still conflict surrounding the role of the ward manager and how that has evolved from that of the ward sister. The difficulty ward managers had in *leading* if they had little clinical input was apparent. A PA/ward clerk/secretary could assist with the business side of the job to free up managers to be out on the ward for more time. Leadership too was challenged by enthusiasm being ground down by the frustration of trying to change things practically at a ward level. The constant reconfiguration process has had an exhausting and demoralising effect on ward managers and staff.

While ward managers and their senior managers were working towards the same goals of caring for patients, clinical staff saw themselves as working for patients, and managers as working to achieve government targets - performance management, beds, turnover - with little comprehension of how the two married up. Clinical staff and managers seemed to speak a different language and the language of management appeared to have little in common with the language of nursing. Yet senior managers described the support ward managers needed in exactly the same terms as the ward managers did themselves; there was much more understanding there than ward managers were enabled to see. Ward managers must to some extent share the 'management speak' of the Trust. But they gave the impression of not having sufficient access to the meaning of Trust imperatives. There was also a perceived lack of honesty and understanding from staff about the Trust's difficulties and what it was trying to achieve.

Conclusion

The research findings have confirmed the view of the LiNEA Steering Group that there is a need to consider staff development for nurses as a more continuous and supported process. Since the inception of the research, competition for stretched resources has increased even further in NHS Trusts, with a serious impact on available posts, particularly for recently qualified nurses. In these circumstances, it is more than ever vital to develop the skills of staff rapidly and effectively and to retain them in the Service. The data have shown what staff themselves, from newly qualified to senior managers, see from their experience would make the difference to their development. The career planning and support in order to move to the next stages of learning and progression to management roles have been found to be non-existent at worst and haphazard and fragmented in many cases. This is of concern at all levels: to nurses, who need to be more forward looking and proactive about what they want to do and in seeking development opportunities; to their managers in making sure staff have equal access to development opportunities and have involved their team in learning with succession planning in mind; and to senior managers, who were aware of many of the difficulties

and development needs faced by staff, although this did not necessarily communicate itself to those staff.

Lack of structured, constructive and positive feedback about competency and performance was reported at all levels. The earlier findings of the LiNEA research showed that constructive feedback has a crucial role in learning for improving skills and confidence, maintaining people's interest in their jobs and enabling them to cope with new challenges. Another point to emerge from the present study was that further learning within an existing role was often wanted in preference to promotion. While this may be a symptom of lack of preparation for promotion and, as was often reported, the negative perceptions of management roles, opportunities for development within a role are important for retention. Furthermore, clinical expertise, leadership skills and management skills may not develop at the same rates, nor are they all necessarily present in one senior person, yet they are all required for ward management. Thus an individual may wish to develop, say their leadership skills but to stay within their post.

There was agreement from all levels of staff that a career development programme from D grade (band 5) to G grade (band 7) needed to be implemented, so that skills and knowledge for the next role can be learnt gradually and with structured support. The production of the programme with the Trust Steering Group was originally included within the aims of the research. However, this has been overtaken by events in the Trust during 2005-6 and the advent of the 'Turnaround team'. This research report will now also be available to that team and provides a strong evidence base to take the programme forward. The investment by the Trust in such a programme will improve the professional working lives of its staff and promote a sense of value and worth within the organisation. Long-term, the development of a structured career pathway could also lead to better recruitment and retention, both of which are central to the delivery of a quality service.