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Exploring senior nurses' experiences of leading organizational change

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DOI:

[10.1108/LHS-03-2015-0005](https://doi.org/10.1108/LHS-03-2015-0005)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Boyal, A & Hewison, A 2016, 'Exploring senior nurses' experiences of leading organizational change', *Leadership in Health Services*, vol. 29, no. 1, pp. 37-51. <https://doi.org/10.1108/LHS-03-2015-0005>

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Publisher Rights Statement:

Amunpreet Boyal , Alistair Hewison , (2016) "Exploring senior nurses' experiences of leading organizational change", *Leadership in Health Services*, Vol. 29 Iss: 1, pp.37 - 51.
<http://dx.doi.org/10.1108/LHS-03-2015-0005>
Checked 21/07/2016

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Title: Exploring Senior Nurses' experiences of leading organizational change

Word count (4955)

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Key Words

Nursing, Health Services Research, Qualitative Methods, Health Service Management

Acknowledgements

The authors would like to thank everyone who participated in the study and the Theme 1 project team for their support. The views expressed in this publication are those of the authors and not necessarily of the NHS, the NIHR or the Department of Health.

Author Contribution

AB was involved in the data analysis. AH was involved in the design of the study and the analysis. AB and AH drafted the paper and were involved at all stages of its production.

Source of Funding

This research was funded by the National Institute for Health Research (NIHR) Birmingham and Black Country Collaborations for Leadership in Applied Health Research and Care (CLAHRC-BBC) Programme.

Conflict of Interest

The authors declare they have no conflict of interest.

Exploring Senior Nurses' experiences of leading organizational change

Introduction

The last decade has been one of unprecedented change in the English National Health Service (NHS) (Shanley, 2007) and internationally (Bouwens and Krueger, 2014). Issues of cost, quality, access, effectiveness, fragmentation of care delivery, and health status outcomes have been driving forces in the restructuring of NHS organizations (Gilmartin, 1996; McMurray, 2010; Hunter, 2005). The policy drive for change continues, focussed on 'a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS' (DH, 2010a, p.6). In addition, the need to deliver high quality health care within stringent financial constraints and to achieve the targets set by the UK government for health care in England (Merali, 2009) presents further pressures on the service. More recently, the recommendations from the Francis Report (Francis, 2013, O'Dowd, 2013), the Berwick Review (Berwick, 2013) and the Department of Health (DH, 2012) indicate that nurses at all levels will be expected to contribute to significant changes in the way services are provided. **This will require national and local leadership of services (Stevens, 2014)**

The requirement to meet targets (including the 18 week referral to treatment time, reducing hospital acquired infections, and treat patients within a maximum period not exceeding four hours for patients to be treated in Accident and Emergency Departments), and the need to make unprecedented productivity improvements (Kings Fund, 2012) are all drivers for organizational change. Nurse leaders play a key role in this as advocates for patients and their profession (Thorpe and Loo, 2003; Bolton, 2003). Indeed, the Department of Health requires that Directors of Nursing ensure their organizations provide high quality care and, as board members, are accountable for agreeing the shape and size of the nursing workforce (DH, 2010b).

As hospitals undergo reorganizations intended to better meet the demands for accessible, cost-effective quality healthcare, nurses' active participation as members of senior management teams is vital (Shanley, 2007). Consequently, new demands are placed on nurses as leaders of change, because not only must they guarantee high quality care and be capable of leading change, they must also deal with budgetary, efficiency, and personnel issues (Salmela *et al.*, 2012). With nurses undertaking more complex and higher level roles (Jasper and Crossan, 2012), it is **important** to examine the concerns, pressures and challenges they face in order to better understand their role during periods of change.

Background

There is a substantial body of literature which examines organizational change (see for example Abrahamson, 2000; Palmer and Dunford, 2008; Sturdy and Grey 2003), yet despite the detailed analysis of the process, prescriptive stepwise models of change dominate the field (Collins, 1998). Work focussing on the process of change indicates that it is not necessarily a process that can be managed (Dopson and Waddington, 1996; Van de Ven and Poole, 1995; Pettigrew *et al.*, 1992), rather it involves creating the right conditions in which change can flourish. This is further complicated by the literature being diffuse and lacking consensus which arises from a lack of clarity in key definitions, conflicting theoretical perspectives, and the sheer volume of material produced. However, there is recognition that attention to the perspectives and experiences of those involved in organizational change can reveal helpful insights on the process (Allan *et al.*, 2014; Buchanan and Badham, 1999; Doyle *et al.*, 2000).

Much of the literature examining nurses' experience of change has focused on middle-level staff (Carney, 2009). **For example their role as 'knowledge brokers' has been investigated**

revealing that ward managers/ward sisters in particular contribute to the organisation of hospitals and have some strategic influence (Burgess and Currie, 2013). Moreover the role of the ward sister/manager as leader has been recognised for many years as crucial in determining the quality of care delivered to patients and the extent to which staff feel supported as team members (see for example Cummings *et al.*, 2010; Fretwell, 1982, 1985; Laschinger *et al.* 2011, McSherry *et al.*, 2012, Pembrey, 1980). Different classifications are sometimes used for such roles, for example Klebeck (2006) does not use the term ‘ward sister’, rather she refers to a registered nurse practicing out of scope, responsible for a particular team or group that delivers nursing service in an acute care organization, employed in a first level management position accountable to a General Manager or Director. Although she reaches similar conclusions about the pressurised nature of the role and the challenges nurses face in balancing its different components in times of organisational change. More recently Allen (2014,2015) has demonstrated the role of qualified nurses as the organisers and coordinators of care in hospitals, and how this is challenging traditional notions of the work of the nurse (Allan, 2014, 2015). However less attention has been given to nurses working at a strategic level with regard to organizational change (Crossan, 2003). It has been suggested that there is a lack of awareness among nurse managers of strategic management concerns in organizations (Carney, 2009), and that understanding and knowledge in this area needs further development (Crossan, 2003). If strategic management is a set of managerial decisions and actions of an organization which facilitate competitive advantage and long-term superior performance over other organizations (Kong, 2008), then the extent to which nurses in acute trusts are engaged in this activity requires investigation. Acute trusts were established to ensure hospitals provide high-quality healthcare and check that they spend their money efficiently. They also determine how a hospital will develop, so that services improve. Some acute trusts are regional or national centres for specialised care, and others are attached

to universities and help to train health professionals (NHS Choices, 2015). They are key organisations in the delivery of services in the English NHS. In view of this, data were collected as part of a study of organizational change to explore Senior Nurses' experiences. The data presented in this article contribute to this emerging area of work.

The Study

Design

The data presented here were collected during the course of a study designed to investigate the drivers, responses, and outcomes of service change in three acute NHS Hospital Trusts over a five year period. The research was conducted as part of the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) programme of work, funded by the National Institute for Health Research (NIHR). It was one of nine CLAHRCs established to bridge the gap between research evidence being developed and its implementation in the NHS (Cooksey, 2006). A key component of this study was a series of longitudinal interviews with senior staff, including senior nurses, in the collaborating Trusts to track their experiences of internal (capital redevelopment) and external (NHS structural reform) change over time. Three rounds of semi-structured interviews were undertaken to access 'strategic level' accounts of organizational change between Spring 2009 and Summer 2012. Seventy seven **were conducted** in the first round, 22 in the second, and 29 in the third. Fourteen senior nurses were involved in these interviews.

The three hospital Trusts collaborating in the study were located in the West Midlands of England and the pseudonyms 'University', 'Urban' and 'Town' have been ascribed to them to maintain the anonymity of the participants. These Trusts were selected as case study sites on the basis that they met the following three key criteria: geographical proximity to each other, were undergoing significant spatial-structural changes and redesign of services (such as

building new hospital facilities or moving services into the community), and agreed to be involved in the study. **This selection was made by the research team, in consultation with the senior management teams of the trusts concerned.** Brief descriptions of each organization can be found in Figure 1.

[Insert Figure 1 here]

Sample/Participants

Participants were recruited using purposive sampling which involves selecting respondents based on their ability to answer the research questions (Teddlie and Yu, 2007). Once the participants had given informed consent, semi-structured interviews were conducted to explore their experiences of organizational change. The respondents included Chief Nurses, Associate Directors of Nursing, Senior Nurses and a Matron (n=14), interviews were conducted between Spring 2009 - Summer 2012. The participants were deemed to be senior if they were involved in Trust Board meetings and had strategic level responsibilities as part of their role. **A formal position in an organisation brings with it authority and legitimacy to lead others (Hartley and Bennington, 2010), and the senior nurses involved in the study reflected this.**

Data collection and analysis

An interview guide was created which included open ended questions designed to encourage respondents to consider their role in leading change **(see figure 2 for examples of the questions used)**. This is a recognised and appropriate method for exploring such issues (Britten, 1995; Corbin and Strauss, 2008). The empirical evidence in this article records Senior Nurses' experiences of organizational change (n=14, Senior Nurses'). The data were

analysed using the Framework Method (FM) (Gale *et al.*, 2013; Ritchie and Lewis 2003). The analytical process involved the coding of data, summarising the codes and then charting them into a matrix (Ward *et al.*, 2013). This served as a basis for the development of key themes which were then refined. As the interviews progressed, the appropriateness of the themes were tested through the process of analysis to inform the final analytical framework (Smith and Firth, 2011). FM supports thematic analysis and provides a systematic model for mapping and managing the data (Ward *et al.*, 2013). Following discussion among the research team of the content of the accounts of the senior nurses, the transcripts were subject to further analysis to identify relevant codes, and themes related to their strategic activity in a manner consistent with the framework method (Gale *et al.*, 2013).

[Insert Figure 2 here]

Validity and reliability/Rigour

In qualitative research, lack of reflexivity on the part of the researcher(s), and the level of rigour and trustworthiness of data can be sources of concern. In order to enhance the reflexivity, rigour and trustworthiness of the research, the team met regularly to review the data analysis process and to cross check emerging themes using the Framework.

Ethical considerations

Ethical approval for the study was granted by the National Research Ethics Service (NRES) (Reference 04/02) which categorised it as 'service evaluation'. The proposal was also considered by a University Ethics Committee and approved (ERN_10-0034). In addition it was registered with the Research and Governance Departments in each Trust.

Findings

Three main themes emerged from the analysis: leadership and workforce; internal influences; and external pressures. Illustrative data extracts are included below in the presentation of the themes and role titles have been included to provide a context for them. In order to maintain the anonymity of the participants, some minor details have been altered.

Leadership and workforce

When the senior nurses were asked about organizational change, leadership was frequently discussed. The need for effective leadership and the development of leaders within organizations was seen as crucial in bringing about change. Being effective was often characterized as ‘strong’ nursing leadership with a professional focus. **This term was used to refer to leaders at ward level who focused on clinical outcomes, who would be firm with staff when necessary, using performance management processes to improve standards of care for example, and inspired and supported their teams.** There was concern that ‘weak’ leaders had a negative impact on teams and organizations which could result in poor practice. **Weak leaders in this context were those who did not challenge their staff when poor performance was evident, and who were unresponsive to the need for change.** At University Trust, respondents also emphasized the importance of having clinical champions and succession planning in place during periods of change:

I think the other challenges over the next year are around how we get a workforce, knowing what we’ve got in the background, how we get the workforce to be, terrible word this but I’m going to say it, but to be leaderful, you know, that whole concept of how do you get a workforce in an organization like this to be led by really good people consistently across your wards. So we know who our really good ward leaders are and a bit like, you know, would you trust them, there’s probably a question somewhere sitting on the bottom of any questionnaire I’d fill in about them saying, you know, are these good leaders, are they safe, would you trust them to run their

wards and I guess it's the same sort of question and I think I come from a fairly reasonable professional basis to be able to do that but, for me it is about how do we get consistent leadership across our organization and where does succession come from. (University - Chief Nurse, Round 3)

There was also discussion of leadership styles and managing staff who did not fulfil the organizations' new requirements for leaders:

I think you do have to be clear in leadership, you know you can't just say oh well, nod them through then, well you can if that's your leadership style but it's not mine. But what that allowed us to do was to send a message to the organization that this was serious, that we had set a new job description, that we were looking for the new clinical leaders of the future, that we had managed to do that, that we offered dignity and professionalism to the three individuals that weren't successful and supported them into whatever career path they needed to do and where possible to retain them, because actually they weren't bad people". (Town - Senior Nurse, Round 3)

At University Trust, Senior Nurses discussed the type of future nurse leaders required in their organization. This was because the risk of having the 'wrong' or 'weak' leaders in departments was not acceptable:

The wrong leader in a ward, the wrong leader in a department, or a person who can't lead and doesn't have the skills to lead, is hugely disruptive. But you get the right leader into a ward and you suddenly begin to see real changes in practice. So what we've really learned is how important it is to identify the leaders. So it's back almost to the very beginning, where I said there are real champions at ground level and above. It's about that leadership role that says we can. Because this place is a 'can do' place, and I think the can do leaders are very important. (University - Chief Nurse, Round 1)

As part of the organizational strategy, University Trust the Senior Nurses were seeking what they termed 'organizational fit'. This referred to a need to ensure that all ward and departmental leaders were 'signed up' to the 'can do' ethos of the trust as a whole. Congruence was sought between leaders at the operational or ward level and the aspirations of the senior and executive nurses. They felt this was particularly important during large scale change. It is perhaps reflective of a particular organizational approach because it did not feature to the same extent in the interviews with Senior Nurses at the other two Trusts:

it's a bit go-getting, I think it's occasionally quite hard-nosed, little bit of arrogance really, less than there was but a little bit of arrogance. A determination to do the right thing rather than to do the thing they're asked to do and a challenge to do it better I think is the way it feels. But a requirement, amongst all of that, to justify your position which I think is one of the strongest elements of this Trust is that, this Trust is about not externally justifying its position but very importantly internally justifying why it's doing what it's doing. And I like that. (University- Chief Nurse, Round 3)

Interviewees also commented on how the promotion of nursing staff had evolved and their concerns about this:

I think the other thing is leadership is key. If you've got a weak ward manager, you're going to have a weak team. And that just nurtures poor practice, and I think historically, some of the ward managers in post didn't get there by interview or merit, it was you went up through the ranks because you've been there x amount of years. And I think we're still suffering from that culture that there used to be, whereas now that's starting to change. So that's why I think people aren't delivering sometimes. (Urban- Senior Nurse, Round 1)

The University Trust's Senior Nurses commented on how it was a large tertiary provider which was ambitious and an exciting place to work. This was expressed to a much lesser extent at the other hospitals where the sense of a Trust identity was not as strong. At Town and Urban Trusts, the respondents indicated that workforce attitudes and behaviours were more conservative and they talked about the loyalty of their staff rather than the 'can do' attitude which was prominent in the accounts of the Senior Nurses at University Trust. Some discussion was taking place about the quality of the workforce, the skill mix of staff and training concerns. At Town Trust for example, the Senior Nurses reported how they were increasing the profile of nursing and getting people 'on the ground' more involved in decision making. They also explained how they divided their time in order to be more visible on the wards in their own leadership role:

my time has been spent probably 60/40 as a true executive working in the last 12 months, 40 around visible leadership embedding systems, going out there checking that things are happening. The previous 12 months I think was much more about, partly on my part understanding the role because it was new to me and to understanding professions in the organization. So then they weren't visible. I think if you were to...do a straw poll, I think you would see now, and we know through some

of the evidence that others benchmark us on, the profile of nursing is significant in the organization now, so where it had no profile before it absolutely has a profile. (Town-Senior Nurse, Round 3)

Although efforts were underway in all three Trusts to develop leaders, this was tempered by a recognition that many staff, particularly at the middle management level had a different approach to leadership which was not necessarily congruent with that of the Senior Nurses. The Senior Nurses reported that they had to become more accepting of those who did not share their vision of leadership in order to empower staff at different levels. This degree of compromise was necessary in order to respond to the range of pressures their organizations faced.

Internal pressures

Different degrees of concern were expressed about the extent to which the need to respond to internal pressures was driving organizational change. **For example in University Trust the need to embed teams following a move to a new hospital site was of concern at the start of the study period, but less so as teams became established. Whereas at Urban Trust an internal change programme was central to the concerns of the senior team.** However, all the interviewees were adamant that they did not let hospital moves or service re-design projects affect the quality of patient care. This was a major challenge and the Senior Nurses reported how they acted to pre-empt problems.

we've used it [Root Cause Analysis] for places where we think the wards don't look as though they're really delivering on its performance. The performance objectives are all slightly out but there's no incidents coming out there but it just doesn't feel right. Let's fetch the ward in and say to them, 'why do you think it's like this?' So rather than saying this ward's got a bad ward leader and the nurses are all lazy because there's always a temptation to be a little bit like that, let's say get the ward leader and the doctors in here to come and talk about, what is it about this ward that means its performance isn't up with the rest of these here?. (University- Chief Nurse, Round 3)

There was much discussion of the need to maintain high standards of care on the wards during periods of organizational change. This centered on the day to day operational challenges the Senior Nurses faced. Dealing with poor practice on the ‘ground floor’ was a constant concern and a vital activity inherent in the role:

the challenges to me...is to keep the wards having good standards, and to enable and ensure the staff are capable of delivering that, and I find every day I’m faced with examples of what I would describe as poor practice. And that to me is my biggest challenge, to root all of that out, and to ensure that the patients are getting the best service, and the care that they should. I think it would be easy to sit back and think, I don’t need to go round my wards every day, because when I go round, this is when I see things, so the more I go, the more I’ll see, and the more of a challenge it becomes. Whereas if I decided to sit back in the office and think let’s just focus on the paperwork and the admin, I wouldn’t see it so it wouldn’t be a challenge...So I suppose I seek the challenge by deliberately looking for it because I want to make sure everything is right, and I think that’s, for me personally, that’s the one thing I find quite frustrating, because nothing is ever as right as it can be. So that’s my challenge. (Urban- Senior Nurse, Round 1)

This is one example of the continuing internal pressures the Senior Nurses had to address.

The need to address these matters prevented them developing a more outward facing strategic perspective on change. It also entailed appraising staff and performance management when corrective action was required to improve care. However, this had to be balanced with raising the profile of nursing as a positive force in the Trust.

we know through some of the evidence that others benchmark us on, the profile of nursing is significant in the organization now, so where it had no profile before it absolutely has a profile. (Town- Director of Nursing, Round 3)

This could be more problematic in specialty areas that they had limited experience or knowledge of, because it was difficult for them to identify what constituted ‘good care’ in such settings. It was challenging for them to develop the knowledge necessary to become more familiar with appropriate quality metrics in these settings because of the time pressures

arising from the demands presented by the complex range of external pressures that had to be contended with.

External pressures

Finances and funding were frequently referred to as external pressures and drivers for change. There was heightened awareness of financial pressures, squeezes and the associated challenges impinging on care (Hurst and Williams, 2012). These included the need to reduce staff costs and make meet overall annual financial savings targets of 5% of turnover (Kings' Fund, 2013). The respondents were concerned this would have an adverse impact on service delivery and patient care reflected by a fall in standards of patient care leading to an increase in hospital acquired infections, pressure sores, and falls. There was discussion of tariffs and how these affected particular services, and cost saving strategies were mentioned in the context of making savings in response to policy directives, such as the need for the NHS to save £20 billion (Appleby *et al.*, 2009). The respondents were seeking to balance their responsibilities to make cost savings, whilst maintaining service standards:

I suppose within the trust the financial sort of situation is going to drive some changes. We've obviously got to become more cost effective and we've obviously got to take an awful lot of money out over the next few years. So that's going to drive changes and I think we're all sort of wedded to the sort of whole QIPP* concept about doing more for less, but doing it better. (Urban- Chief Nurse, Round 2)

I think one of the biggest drivers is that we have to be a business, you know there is a credit crunch we're not going to be getting anymore money from the government, they're not going to be seen to be giving us any money, so we need to make sure that we're financially viable. (Town- Head of Nursing, Round 1)

It was reported that all expenditure had to be justified, consequently if resources or facilities were required for service provision there was a need to 'sell an idea'. Patient need was not a sufficient rationale - business cases were required. Two of the Trusts, Urban and Town, were

in deficit and so finance was a more pressing concern. However, even though University Trust was in the 'black', financial matters preoccupied the respondents there as well:

finance is always at the back of your mind with everything that you do you are always considering what the financial implications are. You don't have an unlimited amount of money, and I don't think people always understand that, I always say to them think about how you run your budget at home. If you want something and you haven't got the money to do it, what would you do? Well I'd wait. So I'd say well why isn't it the same just because you work for the NHS, so when you aren't happy about us saying I can't give you that piece of equipment at the moment, have you got any other way you can... What would you do if you were at home? And you would look at other ways in which to pay for it, and that's what we have to do. So it is trying to get that across to people because they think that you're a manager and that you're being mean and you're just not letting them have something. (University- Senior Nurse, Round 1)

This was also considered to have an impact on care and staff development.

the organization invested £400,000 in the last year, it's investing another £400,000 this year and if we can achieve our financial agenda this year we'll seek to invest another £400,000 next year, it has also enabled at least two to three days a week supernumerary status, i.e. they couldn't manage before because actually they were always dropping nurses, so you know little wonder they had pressure ulcers all over the place because they could never take time to appraise their staff, make sure they're competent, because they're busy delivering care all the time. (Town - Senior Nurse, Round 3)

The respondents were sceptical about the value of targets and felt there were 'too many', and 'we've become very target driven, there's a sort of conveyor belt mentality'. They frequently argued that national targets did not necessarily reflect the quality of care delivered.

Discussion

This study explored the experiences of Senior Nurses during a period of major organizational change. Although the sample size was relatively small this reflects the relative number of nurses in senior management positions. The study has provided some useful data which adds to the evidence base in this field. The implications of the themes derived from the interview data are now explored in more depth.

The importance of ‘strong’, efficient and effective leaders during change was a consistent theme in the respondents’ accounts throughout the period of the study. **Indeed it is a term that has also appeared in recent policy documents (Stevens, 2014, Keogh, 2013).** There was also recognition of the need to develop leaders for the future. These views were founded on a somewhat traditional view of the leader as hero (Kings Fund, 2012), whereas what is required in the increasingly complex world of health care is a ‘cognitive catalyst’ capable of building shared visions and exploiting the diversity of the workforce (Kings Fund, 2011). The somewhat prescriptive requirements the Senior Nurses discussed with regard to the leaders they wanted were at odds with recent work characterizing leadership as a ‘distributed’, shared, collective activity (Currie and Lockett, 2011; Bolden, 2011) that is not reliant on a single individual. Similarly, evidence suggesting the leadership function is ‘co-created’ through the interactions and encounters of people in organizations (Cunliffe and Eriksen, 2011) and that the context, particularly in health care, plays a significant role (Fulop and Mark, 2013) indicates that a reliance on individual leaders alone will not maintain quality and standards in times of change.

In a sense, the focus on leadership was a response to the internal and external pressures the Senior Nurses were facing. There is an extensive evidence base that indicates the crucial role ward leaders play in team leadership and patient care (RCN, 2009, Cummings *et al.*, 2010, Laschinger *et al.*, 2011). Therefore, it is understandable that the Senior Nurses concentrated on this level of activity, albeit drawing on a potentially limited conception of leadership. However clear leadership is also needed at Board level (The Burdett Trust for Nursing, 2006), and although in some of the accounts, the respondents described how they served as a role model, and visited wards to challenge poor practice, there was little discussion of how they functioned at board level.

At Urban and Town Trusts, although the Senior Nurses were in strategic/executive roles, the majority of their time was given over to operational matters rather than longer term strategic management concerns. Which may explain why their accounts related to the specific challenges they faced (reducing infection rates, and meeting other targets), rather than exploring their strategic vision for nursing. There was some consideration of the strategic element of their role by the Senior Nurses at University Trust, however here it was not sustained as operational challenges remained the most immediate concern. So although there was a lack of engagement in strategic activity, as has been found in other settings (Carney, 2009), this was as a result of the need to meet immediate targets and maintain 'business as usual', rather than a lack of interest or desire on the part of the Senior Nurses.

This was also reflected in the respondents' attitude to government policy. Part of acting strategically involves being aware of the environment the organization is operating in to determine how to create competitive advantage (Porter, 1987) and strategic activity requires careful thought, reflection and planning (Mintzberg, 1994). The respondents reported they were too busy doing their 'day jobs' to be overly concerned with external issues, other than reacting to them. There was also little opportunity to plan; rather their work was driven by the need to meet targets. Although they recognised that achieving these targets was not a real reflection of quality of service, which has also been argued by others (Kings Fund, 2010 for example), they had to be addressed and this dominated thinking, preventing any sustained engagement with strategic issues. The general view of the respondents was that in times of change, there was a need to get on with the work, albeit in a reactive way.

Implications

The Senior Nurses were striving to maintain and improve standards of care and were intent on supporting and developing nurse leaders in their organisations to do this. External pressures, financial restrictions and a constant drive to achieve a seemingly increasing number of targets meant that the respondents had little involvement in strategic activity because of the need to respond to these pressures. Concentration on operational issues to maintain stability in periods of change prevented the Senior Nurses influencing strategic decision making in their organizations. If Senior Nurses are to realise their strategic potential then there is a requirement for this group to be given time and support to lead, rather than to react to change. This research indicates that that a ‘nursing voice’ can inform Board level decisions and maintain a focus on patient care.

Conclusion

Senior Nurses were striving to maintain and improve standards of care and they were intent on supporting and developing nurse leaders in their organizations to do this. They attached huge importance to the ‘strength’ of their leaders, redolent of heroic approaches, which have been questioned of late in terms of their appropriateness in health care (King’s Fund, 2011). External pressures, financial restrictions and a constant drive to achieve targets meant that the respondents had little involvement in strategic activity because of the need to respond to these pressures. They appeared constrained in terms of realising the full potential of their role to provide a strategic input from nursing because of the operational demands they faced.

The requirement for Senior Nurse Managers to act strategically and exert influence at a strategic level has been identified (Carney, 2009; Crossan, 2003) and there is an expectation expressed in policy that this will occur (DH, 2010b). This is also seen as a wider

responsibility, for example Blaney (2012) maintains that Senior and executive nurse leadership development is an important aspect of influencing health and care policy and in achieving the best outcomes for the well-being of populations in all countries. However, this study demonstrates this is problematic for Senior Nurses in Trusts. If the strategic potential of this group is to be realised they need to have greater freedom and support to lead, rather than react to change.

* QIPP is an acronym for Quality Innovation Productivity Prevention-a scheme devised by a government agency to improve health service performance (EQIPP, 2013). (EQIPP, 2013).

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