

Adult Nurse Turnover and Retention: South London Project Report

Vari M Drennan, Mary Halter, Robert L Grant, Julia Gale. Ruth Harris, Stephen Gourlay

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The project team:

Carol Beighton, research associate - the literature reviews , FHSCE*

Dr Olga Boiko research associate- the literature reviews, FHSCE

Dr Vari Drennan, Professor of Health Care & Policy Research FHSCE

Holly Elson , project administrator, FHSCE

Dr Julia Gale , Head of School of Nursing FHSCE

Robert Grant , Senior Lecturer in Health and Social Care Statistics , FHSCE

Dr Stephen Gourlay, Associate Professor Kingston Business School , Kingston University

Dr Mary Halter , Senior Research fellow , FHSCE

Dr Ruth Harris , Professor of Nursing FHSCE

Richard Mor, HR consultant

Gail Nicol, HR Business Partner. Greenwich and Lewisham NHS Trust

John Tatam , independent researcher – interviews

Dr Ferruccio Pelone – research associate – the literature reviews FHSCE

*Faculty of Health ,Social Care & Education, Kingston University & St. George's, University of London

Further information about the report

Contact Prof Vari Drennan v.drennan@sgul.kingston.ac.uk

Further Information about Health Education South London

Alison Smith, Head of Workforce Transformation, Health Education South London

Alison.SMITH@southlondon.hee.nhs.uk Stewart House | 32 Russell Square | London | WC1B 5DN .

<http://southlondon.hee.nhs.uk>

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Executive summary

This project was commissioned by Health Education South London (HESL) in response to the workforce planning process for 2014/15 indicating an unprecedented increase in demand for adult nurses in NHS Trusts. The focus of the project was to identify issues and interventions to improve retention of adult nurses and reduce the rate of leaving jobs (turnover). During 2015 the work of the project has included:

- A systematic literature review to examine evidence of determinants , costs and interventions of adult nurse turnover,
- Analysis of adult nurse workforce data to identify trends and rates in sub-groups of nurses and by characteristics of their employment context ,
- Interviews with senior nurse and human resource managers across South London for views and examples of initiatives to reduce turnover
- Interviews with adult nurses and nurse managers as to their views on the issues and initiatives that might help retain nurses.

Key points from each element

1. There is a current and projected on-going demand for adult nurses in South London with multiple types of employers.
2. The NHS has a strong tradition of developing good human resource practices for its entire staff.
3. There are a large number of evidence reviews of the determinants and consequences of adult nurse turnover, and interventions to reduce it. However, when focusing only on reviews meeting recent criteria for the good conduct of a review, the numbers reduce enormously, and, within those, there are few that are judged to be of greater than moderate strength of evidence.
4. The evidence from the good quality reviews is as follows:
 - a. The determinants literature tells us that adult nurse turnover is complex and dependent on factors at a number of levels, from the individual to the organisation;
 - b. The consequences literature is limited but demonstrates the large cost involved in nurse turnover;
 - c. The interventions literature points us to the impact of supportive programmes within organisations, particularly for newly qualified nurses, but remains very limited in relation to any other interventions that could be directed at the range of determinants of turnover identified.
5. There is some evidence that the current guidance be HEE and NHS employers offered to retain adult nurses is supported in part by the research literature regarding the determinants of turnover, within the limitations of this evidence being of moderate strength. Broadly, the guidance addresses factors that nurses report to be of concern in the empirical evidence. Our review however, indicates that intervention studies are almost wholly lacking and we are unable to conclude that the strategies in the guidance will have impact.
6. From the analysis of workforce data for adult nurses across London we see:
 - a. The turnover rate increases with time, rising sharply in 2013 and this is statistically significant. There is no evidence that any single trust deviates from this general upward trend.

- b. The regional difference between North and South London is much smaller than the differences between Trusts, which were greater than could be expected just from statistical fluctuation.
 - c. Looking at nurse characteristics, there is a U-shaped age-sex relationship, where the youngest and oldest nurses are most likely to move on, which is more marked for female than male nurses.
 - d. Ethnic differences are apparent which are quite consistent for South and North London. Turnover is highest in the “White Other” group, followed by “White British”.
 - e. Part-time nurses have a significantly higher turnover rate than full time nurses, even when adjusted for age.
 - f. The work areas with significantly higher adult nurse turnover rates in South London are general medicine, elderly care medicine, neurology, cardio-thoracic surgery and palliative medicine. These may be the work areas that Trusts should prioritise for more in depth analysis and action to inform their nurse retention strategies.
 - g. We intended to analysis in more depth the reasons for leaving posts, particularly in relation to positive and negative reasons, and whether nurses were leaving for other NHS posts or elsewhere. Unfortunately we were unable to do so due to the large amount of missing data. We suggest this is an area that Trusts might consider targeting to improve the data capture for in-depth analysis to inform their action plans.
7. Trust managers are focused on both filling vacancies and also improving retention within their organisations as there is a ‘*vicious cycle*’ of vacancies impacting on retention. Senior nurses segment their nursing workforce to address different types of retention issues over life and career course of nurses. Key elements in Trusts reported include: strategy and leadership and use of data and information to understand the issues. Examples were given of actions addressing issues in: a) remuneration and cost of living, b) progressing a nursing career and progression across the different types of nursing work, and c) the work environment .
8. Adult nurses and their immediate ward managers’ report that there are positive reasons why nurses leave their jobs to those that attract more - for example for experience, career more development, more money , promotion and /or in a more affordable setting . They suggest - Trusts could do more to offer some of this within their organisations. The negative reasons are an interconnected factors that make a job/setting less attractive but it is the build-up of these on top of each other that push nurses from their posts – potential solutions are offered in each category of :
- Remuneration and the cost of living ,
 - Management practices
 - The impact of nurse vacancies
 - Working patterns, patient acuity and staffing
 - The attitudes of patients and relatives
 - Different sub groups of nurses have some specific factors : the older nurses, the new to the profession , the international nurses and the community nurses
9. Adult nurses and their immediate ward managers offer solutions, many of which resided in good management practices and equal and full implementation of the human resource policies. Given the layering of factors that were thought to influence the decision to stay or leave – perhaps the following are ones that make the tipping point and could be addressed: perceptions of equitable treatment with others, being engaged and involved in decisions, being valued as a team member, being supported and praised and simply being treated kindly.

Concluding comments

The report of this project offers evidence as to the scale of the rates of adult nurse turnover for different types of nurses working in different types of service provision. It provides evidence to inform London Trust's management teams, their nurse managers and nurses as to the actions that they could take to retain nurses within their organisations and the NHS. Some factors such as availability of affordable housing require action beyond the remit of an individual Trust. We also point to lack of evidence as to the impact of interventions on this staff group and given that adult nursing shortages are both cyclical and also global suggest some further evaluative research is required .

1 Introduction

This project was commissioned by Health Education South London (HESL) in response to the workforce planning process for 2014/15 indicating an unprecedented increase in demand for adult nurses in NHS Trusts. This increase in demand was attributed to the effects of publication of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and the government response (Department of Health [DH] 2013a, 2014), the findings and recommendations of the Keogh Mortality Review (Keogh 20132) and National Institute for Health and Care Excellent (NICE) guidelines for safer staffing for nursing in adult inpatient wards in acute hospitals (NICE 2014). HESL in discussion with its constituent stakeholders concluded that education commissions would not meet the forecast demand and amongst other objectives, NHS Trusts would work to reduce turnover rates in this group. The commissioning of this project, alongside others, in 2014/15 was in support of this objective. The project benefitted from a HESL steering group with oversight of all the projects commissioned.

1.1 Project objectives

The project objectives were to:

1. Undertake a literature review of the factors influence adult nurse turnover rates and evidence of interventions/activities that have been shown to decrease rates,
2. Analysis anonymous adult nurse workforce data for South London ,provided by HESL, to provide turnover rate norms for sub-groups such as by speciality and provide comparison with other regions and nationally where available,
3. Identify key issues and local evidence of best practices in South London that might reduce the turnover in this staff group through interviews with Directors of Nursing and Directors of Human Resources (or nominated others),
4. Identify key issues and actions to reduce turnover rates through group interviews with frontline nurses and nurse managers in South London,
5. To disseminate the findings of the project in the most useful and accessible way to South London NHS Trusts.

We provide first the context in which adult nurses are employed in NHS and NHS Trusts in South London, before reporting on each of the objectives in turn.

2 The NHS and the South London Context

2.1 The NHS in South London

The National Health Services (NHS) in South London provides services to over three million residents (ONS 2013) in 12 Boroughs , of which four are designated as Inner London (Lambeth, Lewisham, Southwark and Wandsworth) and eight as Outer London (Bexley ,Bromley ,Greenwich , Croydon, Kingston , Richmond , Sutton & Merton) (ONS undated).

2.2 Employers of Adult Nurses in South London

In spring 2015, nurses registered with the Nursing and Midwifery Council (NMC) in the field of practice of adult nursing (called adult nurses throughout this report) were employed by seven acute hospital Trusts. Five of these also provided adult nursing in the community in South London Boroughs as did two other NHS Trusts based in North London (Table 2.1).

| NHS Trusts providing adult acute services in South London | NHS Trusts and community interest companies providing adult community services in South London |
|---|--|
| A) Croydon University Hospital | A) Croydon University Hospital |
| B) Epsom & St Helier University Hospital | B) Guy's & St Thomas NHS Foundation Trust |
| C) Guy's & St Thomas' NHS Foundation Trust | C) Hounslow & Richmond NHS Community Trust |
| D) King's College Hospital Foundation Trust | D) Lewisham & Greenwich NHS Trust |
| E) Kingston Hospital NHS Trust | E) Bromley Health Care |
| F) Lewisham & Greenwich NHS Trust | F) St Georges Health Care Trust |
| G) St Georges Healthcare Trust | G) Our Health |
| | H) The Royal Marsden Hospital |

Table 2.1 NHS Trusts providing adult services in South London (source HESL 2015)

It should be noted that employers of adult nurses in South London also include:

- 493 general practices,
- Numerous commercial and charitable organisations providing care homes, hospices, as well as private hospitals and clinic services.

The NHS Trusts providing adult acute services in south London are large organisations by business definitions but range in size as illustrated by the number of employees (Table 2.2). Nursing , midwifery and health visiting (NMHV) staff account for about a third of their total workforce , reflecting the national picture (377,191 NMHV and 1,387,692 all staff in NHS England [HSCIC 2014]).

| | Number of staff (head count) | Number of nurses, midwives and health visitors (head count) |
|--|------------------------------|---|
| Croydon University Hospital | 3,595 | 1,127 |
| Epsom & St Helier University Hospital | 4,495 | 1,556 |
| Guy's & St Thomas' NHS Foundation Trust | 13,148 | 4,390 |
| King's College Hospital Foundation Trust | 11,605 | 3,945 |
| Kingston Hospital NHS Trust | 2,787 | 888 |
| Lewisham & Greenwich NHS Trust | 6,058 | 2,152 |
| St Georges Healthcare Trust | 8,376 | 2,919 |

Table 2.2 Number of staff and NMHV employed by NHS Trusts providing acute adult services

*Data source NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Organisation Level - Provisional Statistics January 2015 Table 5: NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics: Time series of Staff Totals by Health Education England area and Organisation – Headcount

Fifty five percent (195,370 of the 353,359) N,M,HV in the NHS in England work in acute, elderly and general service areas as at September 2014 (HSCIC 2015). Of these 4% are modern matrons and managers (HSCIC 2015).

2.3 Employment and Human Resource Management Policies in NHS Trusts

NHS Trusts as employers are guided by the NHS Constitution (DH 2013) which specifies the commitments, legal rights (embodied in general employment and discrimination law) and pledges made to staff employed within NHS organisations. The pledges are reproduced in Box 1.

“The NHS commits:

- to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge);
- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge);
- to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge);
- to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge);
- to have a process for staff to raise an internal grievance (pledge);
- and to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998(pledge)”

BOX 1 THE NHS PLEDGES TO STAFF (DH 2013B SECTION 4A)

Current NHS Trust employment and human resource management policies incorporate not only legal requirements but build on decades of national NHS guidance and benchmarks such as the Improving Working Lives Standard (DH 2000). NHS Employers, part of the NHS Confederation, is the currently the source of authoritative guidance on all aspects of human resource practices in the NHS.

NHS Employers is the organisation which works with and on behalf of employers in the health service in England on managing the negotiation infrastructure on pay and terms and conditions,

negotiates specific contracts on behalf of the employers, represent employers on NHS Pension Scheme changes and oversee the development of the national NHS terms and conditions of service handbook for all staff other than senior managers and medical staff known as Agenda for Change. There is a nationally agreed set of NHS terms and conditions (NHS Staff Council 2015). It includes an incremental banded pay system, supported by job evaluation and market facing features such as high cost area supplements (HCAS). The pay scales and pay increases of NHS staff paid under the Agenda for Change system is determined centrally by government ministers, based on the annual recommendations of the NHS Pay Review Body (NHSPRB 2014).

2.4 Turnover and stability rates in all groups of NMHV

The NHS in England uses two measures to understand movement in its workforce:

- the *stability index* – defined as “The percentage (rate) of people (head count) who remained employed within a defined group over a nominated period of time”
- the *turnover rate* defined as: “The percentage (rate) of people (head count) leaving an organisation over a nominated period of time” (HSCIC 2014).

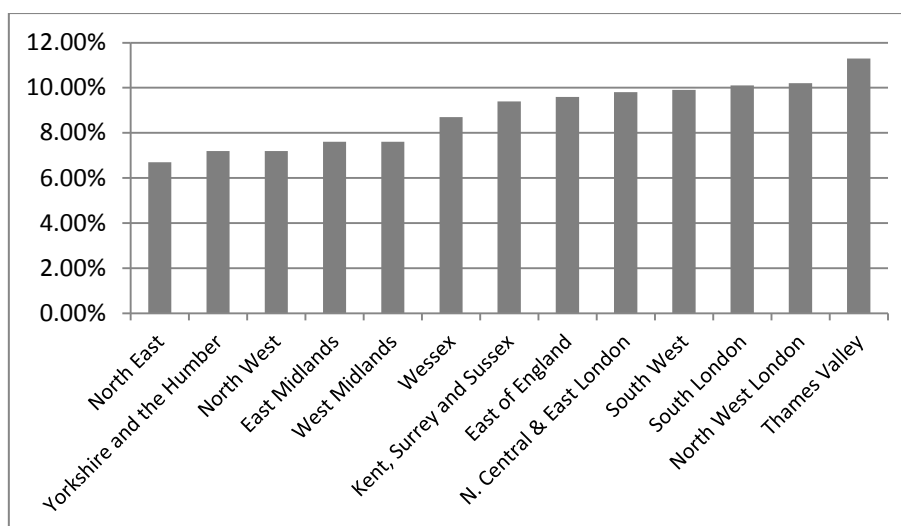
The NHS workforce census reports on the stability index over a 12 month period (HSCIC 2014). Table 1.3 demonstrates the movement in this rate over time and the difficulty of comparisons over time as data definitions and boundaries of reporting organisations change.

| | | September 2007-2008* Qualified Nurses only | January 2012 January 2013** | – | January 2013 January 2014** | – | January 2014 January 2015** |
|---|---------|---|--------------------------------|---|--------------------------------|---|--------------------------------|
| Qualified NMHV in | England | 94% | 92.1% | | 91.8% | | 91.4% |
| Health Education N.Central & East London | | | | | 90.5% | | 89.7% |
| Health Education South London | | 84% | 91% | | 90.9% | | 89.8% |
| Health Education North West London | | | | | 91.4% | | 90.1% |

Table 2.3 Stability Index for qualified nurses in London and England 2007-2015

*Data source HSCIC NHS Staff Turnover Statistics - 2007-2008 Publication date: August 20, 2009 Data source HSCIC NHS Hospital & Community Health Service (HCHS) monthly workforce statistics turnover - selected staff groups - Provisional Statistics January 2013,2014, 2015

There are differences by regional areas and London is a region that usually has high rates of NMHV leavers in N, M, HV compared to most other regions (figure 1.1).



Graph 2.1 Qualified NMHV turnover rate 2014 by LETB

*Data Source HSCIC NHS Hospital & Community Health Service (HCHS) monthly workforce statistics turnover - selected staff groups - Provisional Statistics ENGLAND ,Between January 14 and January 15

We turn now to consider the evidence from the literature review.

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3 The literature review

We undertook both a systematic review of the published literature on adult nurse turnover and also a search for recent guidance in relation to interventions to retaining adult nurses and any unpublished reports by NHS Trusts of successful initiatives in reducing adult nurse turnover rates. We report these in turn.

3.1 The systematic review of the literature

The objectives for the two interlinked systematic reviews of reviews were as follows:

- To appraise and synthesise the published reviews of the determinants and consequences of adult nurse turnover, drawing on reviews of any method;
- To appraise and synthesise the published reviews of the outcomes of interventions to reduce nurse turnover in adult nursing services, in comparison to no intervention, drawing on studies of any method.

Method

We based the reviews methods on the Preferred Reporting Items for Systematic review and Meta-analysis Protocols (PRISMA-P) 2015 statement [Moher et al. 2015] and Cochrane Handbook for Systematic Reviews of Interventions [Becker et al. 2011].

This was a systematic review of reviews including data from qualitative, quantitative and mixed methods reviews. To be eligible for this review the studies had to meet the inclusion criteria given in Table 3.1 and 3.2

| | |
|--------------|--|
| Population | Nurses (i.e. licensed or registered) in adult nursing services (both in hospital and community health services) in advanced economies according to the definition of the International Monetary Fund [IMF 2011] are the population in the majority of the studies included in the review |
| Intervention | Determinants and consequences of adult nursing turnover. |
| Comparison | No specific comparison will be used. All comparators selected for inclusion within the included reviews will be relevant. |
| Outcomes | The outcomes included in the overview will depend on the types of outcomes examined in the retrieved reviews, they may include the following: <ul style="list-style-type: none">- Measures of the outcomes for staff;- Measures of the outcomes for organisations;- Measures of the outcomes for patients. |
| Study design | To ensure that all relevant reviews will be identified, this overview of reviews will include any form of literature review (e.g. either systematic or non-systematic reviews) in accordance with the following criteria: <ul style="list-style-type: none">- Peer-reviewed article;- A statement of review;- Reporting of search strategy and/or inclusion/exclusion criteria |

Table 3.1 Inclusion criteria of review A: determinants and consequences of adult nurse turnover.

| | |
|--------------|---|
| Population | Nurses (i.e. licensed or registered) in adult nursing services (both in hospital and community health services) in advanced economies according to the definition of the International Monetary Fund [IMF 2011] are the population in the majority of the studies included in the review |
| Intervention | Any type of service, management or human resources activity aimed at reducing rates of adult nurse turnover. |
| Comparison | Rate of adult nurse turnover without an intervention, or between two or more interventions. |
| Outcomes | The outcomes included in the review will be: <ul style="list-style-type: none"> - Rates of adult nurse turnover; - Measures of the outcome of interventions on staff, organisations and patients - Descriptions of interventions if no empirical data are presented. |
| Study design | As above |

Table 3.2 Inclusion criteria of review B: interventions to reduce adult nurse turnover

The following additional exclusion criteria were applied:

- Any form of literature review using informal and subjective methods to collect and interpret evidence (including not listing included articles);
- Any review in which majority of included articles are non-peer reviewed publications
- Reviews published only in abstract form
- Reviews that do not report either empirical findings or a list of included primary studies;
- Reviews that did not include a quality appraisal of included papers;
- Reviews published in language other than English;
- Reviews published before 1990.

We searched the following electronic databases: Cochrane Database of Systematic Reviews, MEDLINE (Ovid), EMBASE (Ovid), Applied Social Sciences Index and Abstracts–ASSIA, CINAHL plus (EBSCO), SCOPUS –V.4 (Elsevier) and HMIC (Ovid) from database inception to 2015. Two researchers screened for inclusion. Data was extracted using a pre-defined data abstraction form. The “Assessment of Multiple Systematic Reviews” (AMSTAR) checklist [Oxman and Guyatt 1991] was used to appraise the methodological quality of included reviews.

3.2 Findings: Determinants and Consequences

Nine reviews of determinants and consequences of nurse turnover were included (Box 3.1.)

1. Chan ZC, Tam WS, Lung MK, Wong WY, Chau CW. A systematic literature review of nurse shortage and the intention to leave. *J Nurs Manag.* 2013 May;21(4):605-13.
2. Coomber B, Barriball KL. Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: a review of the research literature. *Int J Nurs Stud.* 2007 Feb;44(2):297-314.
3. Cowden T, Cummings G, Profetto-McGrath J. Leadership practices and staff nurses' intent to stay: a systematic review. *J Nurs Manag.* 2011 May;19(4):461-77.
4. D'Ambra AM, Andrews DR. Incivility, retention and new graduate nurses: an integrated review of the literature. *J Nurs Manag.* 2014 Sep;22(6):735-42. PubMed PMID: 23927565
5. Flinkman M, Leino-Kilpi H, Salanterä S. Nurses' intention to leave the profession: integrative review. *J Adv Nurs.* 2010 Jul;66(7):1422-34.
6. Li Y, Jones CB. A literature review of nursing turnover costs. *J Nurs Manag.* 2013 Apr;21(3):405-18.
7. Schluter J, Winch S, Holzhauser K, Henderson A. Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nurs Ethics.* 2008 May;15(3):304-21.
8. Toh SG, Ang E, Devi MK. Systematic review on the relationship between the nursing shortage and job satisfaction, stress and burnout levels among nurses in oncology/haematology settings. *Int J Evid Based Healthc.* 2012 Jun;10(2):126-41.
9. Wagner CM. Organizational commitment as a predictor variable in nursing turnover research: literature review. *J Adv Nurs.* 2007 Nov;60(3):235-47.

Box 3.1 List of included reviews over determinants and consequences of adult nurse turnover

The evidence in reviews on the factors associated with the outcomes of turnover and/or intention to leave or with retention and/or intention to stay is plentiful, with nine reviews listing a large number of determinants of these outcomes.

For the purpose of clarity, turnover and intention to leave have been treated as directly opposite to retention and intention to stay; that is a determinant that has a positive association with turnover has been considered to giving the same message as the same determinant having a negative association with retention.

Some of the determinants appear only in one review (supported by primary studies of various numbers), while others are repeated in two or more reviews, sometimes one review supporting the evidence of another, sometimes providing contradictory evidence. This quantification is referred to in general terms in the following narrative, although it is the quality of the reviews that gives the evidence greater or lesser weight. The majority of the primary studies included in these reviews were cross sectional studies using self-report survey data from nurses; a smaller number explored the issues qualitatively.

The determinants are presented below, in order of the strength of evidence found in the review of reviews.

No reviews considering determinants have been classified as providing strong evidence. The majority of the reviews of determinants are classified as providing moderate evidence. Within this moderate level evidence the following thematic groupings of determinants have been presented: individual, interpersonal, job/professional, organisational and patient-related factors. Each of these groups, and their sub-themes from the literature, are considered in turn.

(i) Individual nurse determinants

Two groups of factors were considered among individual nurse determinants. The first group of findings involved sociodemographic characteristics, some are given characteristics such as age and gender, whereas others are acquired - education and family status. The second group described associations with psychological experiences of nurses – stress, burnout, commitment and job satisfaction. Additionally, the impact of biological factors (low serum cholesterol, underweight, sleep disturbance) on intention to leave is considered in one review (Chan, Tam, Lung et al. 2013).

Age features in two reviews, of which one (Chan, Tam, Lung et al. 2013) reports more consistently that older nurses (defined as aged over 45) are likely to remain, although this contrasts with a reported intention to retire in nurses aged over 50 from another review (Flinkman, Leino-Kilpi and Salatera 2010). Nurses aged over 35, those younger than 25 and newly qualified, or who have worked for fewer than five years are more likely to leave (Chan, Tam, Lung et al. 2013).

The same review found that male nurses more often have intention to leave than females. More educated nurses, those with diploma and better attainment levels are more likely to leave according to three reviews (Chan, Tam, Lung et al. 2013; Coomber and Barriball 2007; Toh, Ang and Devi, 2012) based on six studies. Unmarried nurses are found to be more likely to leave – a finding evidenced in three primary studies (Chan, Tam, Lung et al. 2013).

Among psychological experiences, stress and burnout are considered as negative experiences which are more likely than not to influence a decision to leave. Three reviews report on single studies that consider separately work-related stress (Coomber and Barriball 2007), stress related to the role overall with dissatisfaction of career prospects (Flinkman, Leino-Kilpi, Salatera 2010), and moral stress originated in the hospital ethical climate (Schluter, Winch, Holzhauser et al 2008). Similarly, the negative influence of burnout and emotional exhaustion receives support in two reviews (Chan, Tam, Lung et al. 2013; Toh, Ang and Devi, 2012), in a total of four papers.

Job dissatisfaction received strong support as a determinant of leaving. Four reviews reporting a total 16 studies uniformly concluded on its influence (Chan, Tam, Lung et al. 2013; Toh, Ang and Devi, 2012; Coomber and Barriball 2007; Flinkman, Leino-Kilpi, Salatera 2010). However dissatisfaction could have been mediated by a number of other factors independently predisposing to turnover and to intention to leave – among others cited are staffing, workload, low salary and general job dissatisfaction. Its counterpart, job satisfaction, featured as a positive psychological experience in three reviews, although with less convincing associations with intention to stay (Chan, Tam, Lung et al. 2013; Toh, Ang and Devi, 2012; Coomber and Barriball 2007).

Commitment is also considered as a positive psychological experience influencing intention to stay by two reviews. One review reports uni-directional impact (Chan, Tam, Lung et al. 2013): four primary studies they reviewed suggest negative links of organisational commitment with intention to leave. Another review considered different vectors (five papers report on commitment as having negative relations with intention to leave, whereas two papers - on low commitment as positive with intention to leave) and different types of commitment (Flinkman, Leino-Kilpi, Salatera 2010).

(ii) Job-related or professional determinants

A number of job-related or professional factors have been reported to be associated with turnover or retention:

- *Workload*, including demanding work content (Chan, Tam, Lung et al. 2013), high workload (Chan, Tam, Lung et al. 2013), work stress due to high workload (Coomber and Barriball, 2007), as well as variation in work tasks or role ambiguity (Chan, Tam, Lung et al. 2013) increased intention to leave
- *Working patterns*, such as shift work (evenings and night shifts mentioned specifically) (Chan, Tam, Lung et al. 2013) and instability of a constantly changing rota increased turnover as a specific stressor (Coomber and Barriball, 2007) were reported to equate to a moderate intention to leave.
- *Absence of continuing professional development*, namely a lack of development opportunities for professional growth (Chan, Tam, Lung et al. 2013; Flinkman, Leino-Kilpi and Salantera, 2010) increased intention to leave
- *Role conflict* has also been suggested to be a determining factor in decreasing a nurse's intention to stay in one study in one review (Chan, Tam, Lung et al. 2013), while another review (Flinkman, Leino-Kilpi and Salantera, 2010) reported a study providing conflicting quantitative and qualitative findings from the same group of nurses, but essentially suggested that more experienced nurses (how they saw themselves professionally) indicated an intention to stay.

(iii) Interpersonal determinants

The factors considered in this theme are leadership, management, supervision and team or group working. The evidence from a number of reviews tells a consistent story here, albeit presented often in opposing directions, e.g. a positive managerial style reported as increasing retention while the directly opposite negative managerial style is reported as increasing turnover.

Those determinants presented are as follows:

- *Leadership practices* - management by exception, reported in two primary studies, or autocratic leadership in one other (Cowden, Cummings and Profetto-McGrath, 2011) are suggested to increase turnover or intention to leave. Looking at this conversely, transformational leadership practices is seen, in a number of studies, and trust reported in the same review (Cowden, Cummings and Profetto-McGrath, 2011) as influential in intention to stay.
- *Management style* - lack of staff autonomy, empowerment and decision-making, from three primary studies or generally poor management in another (Chan, Tam, Lung et al. 2013) are associated with turnover, while the direct opposites – staff empowerment, control over practice and shared decision making, linked by some to a perception of their leader's power and influence in the organisation - significantly increase intention to stay in a number of studies reported by Cowden, Cummings and Profetto-McGrath (2011). Good communication was also seen as a positive in intention to stay (Chan, Tam, Lung et al. 2013).
- *Lack of supervisory support* (Cowden, Cummings and Profetto-McGrath, 2011; Coomber and Barriball, 2007) are listed as determinants for turnover or intention to leave. In the same way, supervisor support, as well as and praise and recognition are noted to be positively related to intention to stay in a number of primary studies reported in one review (Cowden, Cummings and Profetto-McGrath, 2011).
- *Peer relations* – low evidence of teamwork (Chan, Tam, Lung et al. 2013), or lowered group cohesion (and associated lowered job satisfaction) resulting from high job stress (Coomber and Barriball, 2007). Supporting this are the reviews, suggesting that achievement of group cohesion (Cowden, Cummings and Profetto-McGrath, 2011) and peer support in terms of social support from supervisors and co-workers, reported in one study (Chan, Tam, Lung et al. 2013) are considered to increase intent to stay.

(iv) Organisational determinants

A number of structural and cultural organisational level determinants were considered to be variously associated with turnover – pay, organisational size, organisational culture.

Of these, pay received the most attention in two reviews (Chan, Tam, Lung et al. 2013; Coomber and Barriball, 2007) with dissatisfaction with pay and benefits reported as associated with intention to leave in a number of studies, while others suggest that pay alone is not a predictor, rather its impact is confounded with job dissatisfaction (Coomber and Barriball, 2007). Sub-analysis of pay also reveals pay was particularly an issue for male nurses (Coomber and Barriball, 2007) in one study and when considered inequitable in relation to a high level of responsibility (Coomber and Barriball, 2007) in another study.

The organisational culture was considered to impact through greater intention to leave where the 'ethical climate', that is the organisational conditions affecting difficult patient care decisions, reported in two of the reviews (Chan, Tam, Lung et al. 2013; Schluter, Winch, Holzhauser et al, 2008) as well as the more generally termed 'poor work environment' or 'lack of resources' in other studies the review reports (Chan, Tam, Lung et al. 2013). Conversely, when an organisational culture is described as providing a core identity or collectivist orientation, review evidence (Chan, Tam, Lung et al. 2013) from three primary studies suggests that turnover is reduced.

Organisational size was considered influential in one review (Chan, Tam, Lung et al. 2013), with smaller outpatient and day care units seeing lower turnover.

(v) Patient-related determinants

Patient-related determinants were considered directly in just one review (Chan, Tam, Lung et al. 2013), although closely related to the concept of ethical climate considered above. Here intention to leave was positively related to nurses' dissatisfaction when unable to provide high quality patient care in one study or satisfy personal standards due to staff shortages in another and, supporting this, negatively related to intention to leave when able to adhere to job standard in another study.

(vi) Consequences of turnover

The literature regarding the consequences of turnover is extremely scant, with only two reviews identified which addressed this issue, and both of these focusing on financial consequences alone. These reviews were classified as being of moderate strength and rely on completely overlapping primary studies, that is, the same 11 studies are reviewed in both (Coomber and Barriball, 2007; Li and Jones, 2013).

The cost consequences of turnover considered are described variously: total costs, costs per nurse, learning costs (decreased productivity), costs relative to departmental salary expenses, vacancy costs, costs of orientating and training nurse hires. While the financial costs reported vary in the reviews, due to the different chronological and physical settings of the primary studies included, the message is clear that all of these costs are negative consequences.

3.3 Findings: Interventions to reduce nurse turnover

Seven reviews were included of reviews of interventions to reduce nurse turnover as listed in box 3.2.

1. Chen CM, Lou MF. The effectiveness and application of mentorship programmes for recently registered nurses: a systematic review. *J Nurs Manag.* 2014 May; 22(4):433-42.
2. Cowden T, Cummings G, Profetto-McGrath J. Leadership practices and staff nurses' intent to stay: a systematic review. *J Nurs Manag.* 2011 May; 19(4):461-77.
3. Lartey S, Cummings G, Profetto-McGrath J. Interventions that promote retention of experienced registered nurses in health care settings: a systematic review. *J Nurs Manag.* 2014 Nov; 22(8):1027-41.
4. Park M, Jones CB. A retention strategy for newly graduated nurses: an integrative review of orientation programs. *J Nurses Staff Dev.* 2010 Jul-Aug;26(4):142-9.
5. Rush KL, Adamack M, Gordon J, Lilly M, Janke R. Best practices of formal new graduate nurse transition programs: an integrative review. *Int J Nurs Stud.* 2013 Mar;50(3):345-56.
6. Salt J, Cummings GG, Profetto-McGrath J. Increasing retention of new graduate nurses: a systematic review of interventions by healthcare organizations. *J Nurs Adm.* 2008 Jun;38(6):287-96.
7. Swenty CF, Schaar GL, Phillips LA, Embree JL, McCool IA, et al. Nursing sabbatical in the acute care setting: what is the evidence?. *Nurs Forum.* 2011 Jul-Sep;46(3):195-204.

Box 3.2 Included reviews to reduce nurse turnover

Six of the reviews were judged to be of moderate quality (Chen and Lou 2014; Cowden et al 2011; Lartey et al 2013; Park and Jones 2010; Rush et al 2013; Salt et al 2008), although three (Salt 2008 Chen 2014, Rush 2013) scored at the top of the range in this category.

Interventions focused on retention of newly graduated nurses (NGNs)

At the individual level, interventions were heavily but not exclusively focused on newly qualified /graduated nurses (NGNs), and on **supportive programmes of transition or development** (variously named , including the terms residency, internship and orientation as well as mentoring and preceptorship), with preceptorship – one-to-one guidance through clinical experience - as a component of the majority, alongside a range of programme components (for example classroom learning or group discussion) and support systems (for example the programme director or clinical educator). The evidence for each type is as follows:

- *Residency* received positive support in four reviews (Salt et al 2008; Park and Jones 2010; Rush et al 2013; Chen and Lou 2014), reporting several studies, including a small number using experimental designs.
- *Internships* also received some emphasis as positive for retention (Salt et al 2008; Park and Jones 2010), as did orientation programmes for transition (Salt et al 2008; Park and Jones 2010; Rush et al 2013) as positively impacting on turnover in four primary studies.
- *One to one mentorship programmes of three months' duration* were reported as essential to retaining newly registered nurses, reducing turnover in two studies (from the USA and Taiwan) in one review (Chen and Lou 2014).
- *Preceptorship* there was supportive evidence in one review (Salt et al, 2008), from 10 studies from the USA, all of which were experimental in design, albeit case studies or non randomised control designs. A note on preceptorship in the UK is given in box 3.3.
- *Externships* Evidence for the positive impact of externships (preceptor and employment experiences of the student nurse the year before graduation from a basic RN education programme) was limited to one study reported in Salt et al (2008).
- *Needs-based training or specialty training* programmes (designed to develop skills for specific clinical areas and including classroom instruction, observational experience, journaling, case study, coaching, and computer-based training) was also reported to increase retention (Salt et al, 2008).

These reviews vary in how actual turnover rates are reported, making comparison difficult and few studies had strong enough designs to rule out other explanations (Rush et al 2013).” With the same

caveats about strength of evidence, longer transition programmes (up to one year) appeared to achieve better results regarding turnover (Salt et al 2008; Rush et al 2013).

Note on preceptorship in nursing in the UK .

This is a term used specifically with regard to newly qualified nurses, midwives and health visitors in the UK and the NMC note :” Newly qualified nurses cannot be expected to have extensive clinical experience, specialist expertise, or highly developed supervision and leadership skills. Opportunities will be needed to develop these through preceptorship and ongoing professional development” (NMC 2010 p5) . The NMHV defines the term as follows :

“ *Preceptor* A registered nurse who helps newly qualified nurses develop confidence and reinforce their knowledge and skills after their initial registration.

Preceptorship The support and guidance that enables qualified nurses to make the transition from being a student to becoming a more confident practitioner to practise in line with NMC Standards (NMC 2010 p 149)”. Before March 2013 the successful completion of a preceptorship programme was linked to the accelerated pay progression, two increments in year one as part of the NHS terms and conditions (Agenda of Change).

Box 3.3. Note on preceptorship in nursing in the UK

Interventions at the leadership level

Two reviews addressed interventions at the leadership level. Management training in leadership behaviour featured in one study in one review (Lartey et al 2014), and supervision support in seven primary studies in another review (Cowden et al 2011), as significantly related to intent to stay.

Interventions at the organisational level

Two reviews considered interventions at the group or organisational level. Cowden et al (2011) discuss nine primary studies where group cohesion is reported as significantly associated with intention to stay. However, no detail is given about the nature of the interventions. Lartey et al (2014) also describe a positive impact of one year team oriented interventions (one of team discussion groups, the other undefined) on turnover and mixed evidence of effect of nursing practice models, widely used by accredited Magnet hospitals in North America.

One review was judged to be of poor quality, with high risk of bias. This review (Swenty et al 2011) suggested that a clinical practice sabbatical (a leave of absence for an identified purpose) for nurses in acute care settings was a viable strategy to increase retention. However, at best the review included descriptive studies and at worst anecdotal accounts. The review authors conclude that the evidence is limited.

3.4 Conclusions from the systematic review of reviews

The numbers of reviews of the determinants and consequences of adult nurse turnover, and interventions to reduce it is large. However, when focusing only on reviews meeting recent criteria for the good conduct of a review, the numbers reduce enormously, and, within those, there are few that are judged to be of greater than moderate strength of evidence. The determinants literature tells us that:

- Adult nurse turnover is complex and dependent on factors at a number of levels, from the individual to the organisation;
- The consequences literature is limited but reminds us of the large cost involved in turnover;
- The interventions literature points us clearly to the impact of supportive programmes within organisations, particularly for newly qualified nurses, but remains very limited in

relation to any other interventions that could be directed at the range of determinants of turnover identified.

3.5 Scoping Current Guidance and Initiatives within the NHS

We searched the internet using search engines and key words as in the literature review. We also searched national level organisations' websites such as NHS Employers, Health Education England , the Royal College of Nursing , the Centre for Workforce Intelligence(CfWI) , the Kings Fund , the Nuffield Trust and the Health Foundation .

Concerns about the supply of nurses over the last 2-3 years are evident from the CFWI report on future nursing workforce projects (CfWI 2013), the NHS Employers survey of NHS Trusts in England on the supply and demand for nurses (NHS Employers 2014) and HEE published literature review on nurses leaving the NHS (HEE 2014) the launch of initiatives such as HEE Return to Nursing campaign (<http://comeback.hee.nhs.uk/>) . The HEE review (HEE 2014) helpfully reminds the reader of the NHS nursing shortages at the start of the millennium (Finlayson et al 2002). , the policy response to turnover (DH 2000) and the implementation follow up with regard to nurses (NHS Executive 2000). Other unpublished literature is also available from this period for example the Kings Fund Report on explaining the NHS nursing shortage (Meadows et al 2000).

The scoping identified that many NHS Trusts have publically available workforce and organisational strategies for all their staff, including nurses, which address the NHS Constitution staff pledges (DH 2013) as well their own organisations' strategic plans. Many NHS Trusts also have publically available Strategies for Nursing which in the main are framed by the Department of health and NHS Commissioning Board national Nursing, Midwifery and Care Staff vision and Strategy – compassion in practice (DH NHS Commissioning board 2012) . Of those we reviewed retention of nurses was often mentioned in relation to the provision of learning and development under the C of competence.

3.5.1 Nationally available guidance on retention

We identified two guidance documents on retention: one from Health Education England focused on nurses and one from NHS Employers (not specifically focused at nurses). Neither are robust in providing their evidence base from which they draw their recommendations.

The HEE review (HEE 2014, NB no authorship is given) is not a systematic review, does not describe the method of the review and gives no indication of the quality of the evidence it draws on. It argues that “ *central to retaining nurses is the development of a supportive work environment that prevents intention to leave the profession as well as actual leaving. In addition being embedded in an organisation is critical to reducing actual staff turnover* ”p16. It then offers the following key points for retention strategies as listed in Box 3.3:

1. “Determine levels of intention to leave, stress and burnout and monitor the impact of strategies to improve
2. Make improving retention and staff engagement a key strategy
3. Develop nurse leaders and nurse line managers
4. Provide flexible scheduling options
5. Review patient case mix and align staffing and tasks
6. Provide mentorship and continual professional development
7. Provide rewards and recognition for high performers
8. Invest in the nurse workforce
9. Focus on newly qualified nurses
10. Provide flexible retirement options
11. Develop and continue staff engagement
12. Promote stress management
13. Promote positive nurse – physician relationships
14. Promote connections internally and externally” .section headings from pages 17-23)

Box 3.3. HEE Review on growing nursing numbers (2014)

The NHS employers checklist on good practice in staff retention (2015) has been derived from an consensus event, in which the participants and processes are not described. The checklist is given in box 3.4

- 1) *Know your workforce.* It is important to review organisation-wide workforce data and for managers to be able to drill down into this by department and team to review, compare and learn. Gather and use data and intelligence information on the following: Numbers in post, Age profile, Vacancy rates, Duration of time to hire, Sickness absence figures, Appraisal rates and what they tell you, Individual working patterns and how often these are reviewed, Collect and review exit interview information, NHS Staff Survey, local pulse survey and Staff Friends and Family Test results,, Complaints, grievances and raising concerns data
- 2) Review the effectiveness of your staff engagement plans and activity.
- 3) Test whether your engagement and communication routes with managers around people management issues are effective.
- 4) Review recruitment and selection processes, induction and preceptorship
- 5) Consider how your values are used in recruitment and throughout the employee life cycle.
- 6) Review your health, work and well-being strategy and its effectiveness
- 7) Look at your whole reward package and how you describe this to potential new recruits as well as your current workforce.
- 8) Explore if your e-rostering practice is compatible with encouraging flexible working
- 9) Review your approach to flexible retirement options
- 10) Review your approach to talent management and development
- 11) Understanding the impact of activity. Build time and measures into your retention plan to enable you to reflect on what has and hasn't worked. Drill down into team level data.
- 12) Use some of the data sets identified to help you track trends, highlight where additional detail from an area may be needed or where something is working well so that you can look to replicate it.

Box 3.4 Staff retention: a good practice checklist (NHS Employers 2015)

A comparison of the available guidance on retention of nursing in England and the evidence from our literature review is presented in the following table (3.3):

Table 3.3. A comparison of HEE advice, NHS employers checklist on retention and evidence from the systematic review

| Item in HEE guidance (.section headings from pages 17-23) | Item in NHS employers | Evidence to support this from the systematic review on determinants | Evidence to support this from the systematic review on interventions |
|---|---|---|--|
| 1. Determine levels of intention to leave, stress and burnout and monitor the impact of strategies to improve | Review your health, work and well-being strategy and its effectiveness | 3 reviews of moderate strength of evidence on stress increasing turnover rates (Coomber & Barriball 2006, Flinkman et al 2010, Schluter et al 2008). 2 reviews of moderate strength of evidence that stress and burnout are determinants in intention to leave effects (Chan et al 2013, Toh et al 2012). | |
| 2. Make improving retention and staff engagement a key strategy | Understanding the impact of activity. Build time and measures into your retention plan to enable you to reflect on what has and hasn't worked. Drill down into team level data. | 3 reviews of moderate strength of evidence on group cohesion increasing intention to stay (Cowen et al 2011, Chan et al 2013, Coomber & Barriball 2006). 1 review of moderate strength on teamwork, peer support and communication as positively associated with intention to stay (Chan et al 2013). | |
| 3. Develop nurse leaders and nurse line managers | | 2 reviews of moderate strength of evidence on transformative (participative) leadership and supervisory support influencing intention to stay (Cowden et al 2011, Coomber & Barriball 2006). 1 review of moderate strength of evidence suggesting association of poor management with intention to leave (Chan et al 2013). 1 review of moderate strength of evidence on links between manager's characteristics (power) and intention to stay (Cowden et al 2011). | Management training in leadership behaviour featured in one study in one review (Lartey et al 2014), and supervision support in seven primary studies in another review (Cowden et al 2011), as significantly related to intent to stay. |
| 4. Provide flexible scheduling options | Explore if your e-rostering practice is compatible with encouraging flexible working | 1 review of moderate strength of evidence on heavy workload such as demanding hours, evenings and night shifts influencing intention to leave (Chan et al 2013). | |
| 5. Review patient case mix and align staffing and tasks | | 2 reviews of moderate strength of evidence on staff shortages positively associated with intention to leave and turnover (Chan et al 2013, Schluter et al 2008). 1 review of moderate strength of evidence on low quality of care associated with intention to leave (Chan et al 2013). | |

| Item in HEE guidance (.section headings from pages 17-23) | Item in NHS employers | Evidence to support this from the systematic review on determinants | Evidence to support this from the systematic review on interventions |
|--|---|--|--|
| 6. Provide mentorship and continual professional development | Review recruitment and selection processes, induction and preceptorship | 2 reviews of moderate strength of evidence on lack of possibilities for development and promotion influencing intention to leave (Flinkman et al 2010, Chan et al 2013). | |
| 7. Provide rewards and recognition for high performers | Review your approach to talent management and development | 2 reviews of moderate strength of evidence on perceived low pay and lack of remuneration determining intention to leave (Chan et al 2013, Coomber & Barriball 2006). | |
| 8. Invest in the nurse workforce | | 2 reviews of moderate strength of evidence on cost consequences of turnover (Li & Jones 2013, Coomber & Barriball 2006). | Lartey et al (2014) describe a positive impact of one year team oriented interventions (one of team discussion groups, the other undefined) on turnover and mixed evidence of effect of nursing practice models, widely used by Magnet hospitals in North America. Cowden et al 2011), reported supervision support in seven primary studies as significantly related to intent to stay. |
| 9. Focus on newly qualified nurses | Review recruitment and selection processes, induction and preceptorship | | 5 reviews of moderate strength of evidence (Chen and Lou 2014; Cowden et al 2011; Lartey et al 2013; Park and Jones 2010; Salt et al 2008) suggests that retention of newly graduated nurses (NGNs) is increased through the following strategies: <ul style="list-style-type: none"> • Preceptorship programmes • Needs-based training or specialty training programmes • Externship (preceptored and employment experiences of the student nurse the year before graduation). |
| 10. Provide flexible retirement options | Review your approach to flexible retirement options | | |
| 11. Develop and continue staff engagement | Review the effectiveness of your staff engagement plans and activity | 2 reviews of moderate strength of evidence on staff autonomy, empowerment and decision-making improving intention to stay (Cowden et al 2011, Chan et al 2013). 2 reviews of moderate strength of evidence on staff commitment decreasing intention to leave (Chan et al 2013, Flinkman et al 2010), the finding also | Lartey et al (2014) describe a positive impact of one year team oriented interventions (one of team discussion groups, the other undefined) on turnover and mixed evidence of effect of nursing practice models, widely used by Magnet hospitals in North America . |

| Item in HEE guidance (.section headings from pages 17-23) | Item in NHS employers | Evidence to support this from the systematic review on determinants | Evidence to support this from the systematic review on interventions |
|---|---|--|--|
| | | supported by 1 review of weak strength of evidence (Wagner 2007). 4 reviews of moderate strength of evidence on job dissatisfaction determining intention to leave (Chan et al 2013, Toh et al 2012, Flinkman et al 2010, Coomber & Barriball 2006). | |
| 12. Promote stress management | | 1 review of moderate strength of evidence suggesting the (positive) impact of work environment and organisational culture on intention to leave (Chan et al 2013). (Also see N 1 for stress as a factor) | |
| 13. Promote positive nurse – physician relationships | | | Lartey et al (2014) describe a positive impact of one year team oriented interventions (one of team discussion groups, the other undefined) on turnover and mixed evidence of effect of nursing practice models, widely used by Magnet hospitals in North America. |
| 14. Promote connections internally and externally” | | | |
| | Know your workforce through data analysis. Use some of the data sets identified to help you track trends, highlight where additional detail from an area may be needed or where something is working well so that you can look to replicate it. | | |
| | Test whether your engagement and communication routes with managers around people management issues are effective. | | |
| | Consider how your values are used in recruitment and throughout the employee life cycle | | |
| | Look at your whole reward package and how you describe this to potential new recruits as well as your current workforce. | 2 reviews of moderate strength of evidence on perceived low pay and lack of remuneration determining intention to leave (Chan et al 2013, Coomber & Barriball 2006). | |

3.5.2 Conclusion regarding the application of the systematic review evidence to current HEE and NHS employer guidance

There is some evidence that the current guidance be HEE and NHS employers offered to retain adult nurses is supported in part by the research literature regarding the determinants of turnover, within the limitations of this evidence being of moderate strength. Broadly, the guidance addresses factors that nurses report to be of concern in the empirical evidence. Our review however, indicates that that intervention studies are almost wholly lacking and we are unable to conclude that the strategies in the guidance will have impact.

We turn now to the South London evidence in the following chapters.

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4 Analysis of adult nurse workforce data in south London

4.1 Introduction

The national guidance for NHS Trusts considering turnover statistics is to look at sub-groups rather than organisations rates (HSCIC 2014). This analysis addresses questions as to rates within and between the sub-groups in the generic group termed adult nurses in South London both by demography, professional and work factors and by different types of employing organisations. These questions have been informed by the literature review on determinants of nurse turnover and also by the interviews with the nurses and human resource managers described in the following two chapters.

It addresses the following questions:

1. What is the rate of turnover in adult nurses in South London and how does this compare with other parts of London and other geographical areas?
2. Does the turnover rate differ by:
 - Demography - gender , age band, ethnicity
 - Professional characteristics – newly qualified , pay band , new to the NHS, job role
 - Work characteristics – full or part time working , area of work (as defined at secondary and tertiary levels in the NHS minimum workforce data set)
 - Employing organisations as inner or outer London Trusts
3. What is the rate of adult nurses leaving within 6 months and between 7-12 months of taking up post in an organisation?
 - Does that rate differ by any of the above bullet points in question 2?
4. What are the reasons for leaving an organisation, and what percentage is for positive reasons compared to negative reasons?
 - Do the rates differ by any of the bullet points above in question 2?

4.2 Methods

Data sources

Anonymous workforce data was kindly provided by HESL. Data files for all leavers from nursing posts in London between March 2011 and March 2014 were cleaned and reduced to relevant roles. Mental health trusts, without general community nursing services for adults , were removed along with some that are not clearly north or south of the Thames. Community and acute nurse posts were retained, but not any employed by PCTs or CCGs. Trusts were anonymised with consecutive random numbers, with the key stored separately. Data files containing every staff member in post as a snapshot each quarter were reduced in the same way and matched to the leavers. To do this, individuals with multiple posts had to be matched on the basis of all available variables.

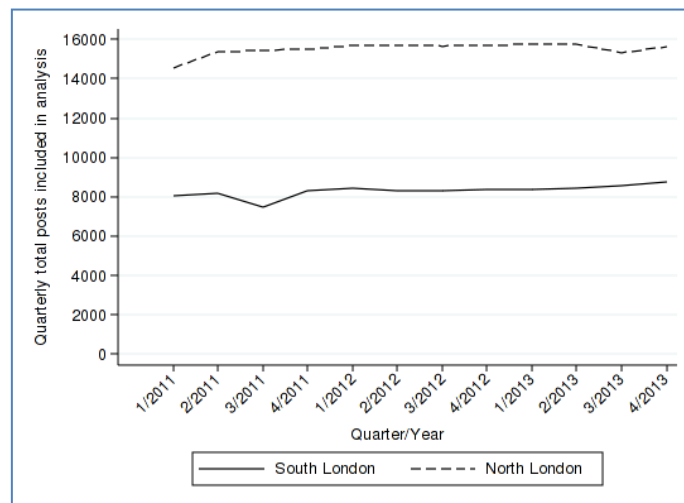
Analysis

For every combination of covariate (quarter & year, sex, age band, trust, North/South London, job role, area of work, ethnicity, full time post, pay band, destination on leaving, reason for leaving) values, the number of posts, leavers, leavers within 6 months, and leavers within 1 year is counted. This then allowed us to calculate rates of leaving in various forms against the denominator of the number of posts. Confidence intervals were calculated using the standard epidemiological formula. Poisson regression was used to adjust for potentially confounding factors. Stata software, version 13

was used for all analysis and data handling. A file containing all the Stata code is available on request.

4.3 Results

We analysed data on 3000 leavers and an average of 8300 posts (averaged over the three years; see the graph below for trends in the number of posts) in South London. For North London, there were 5744 leavers and an average of 15512 posts. There were 29 trusts included, with a mean of 887 posts per trust (median 626). A large number of nursing posts ended and started again by TUPE in one particular quarter at one trust, and their data was excluded entirely for that quarter. This causes a drop in the total South London posts, seen in the graph (1) below.



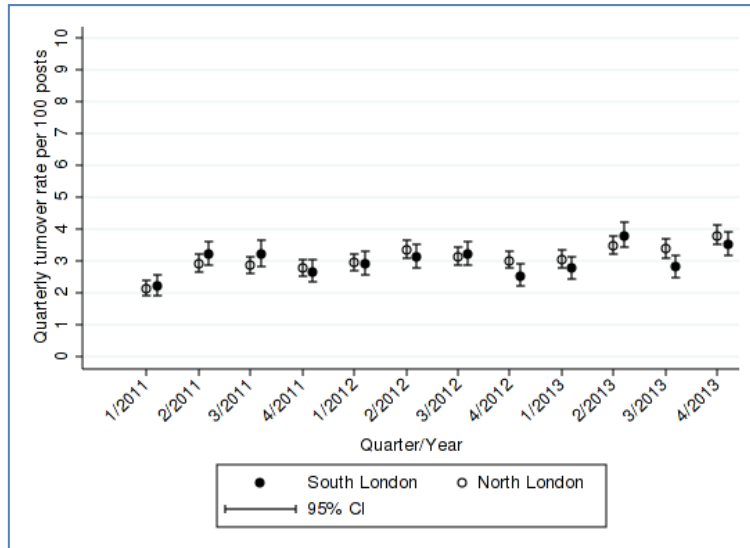
Graph 1 Number of adult nurse posts in North and South London 2011-2013

Matching leavers to their posts is not straightforward because of multiple posts held by the same person, and time lag in recording the post after the appointment. By taking the quarterly snapshot data of staff in post from three months prior to the leavers' data, we optimised the matching at about 95% of records. We address each of our questions in turn.

4.3.1 *What is the turnover rate of adult nurses in South London and how does this compare with other parts of London and other geographical areas?*

We only have data from South and North London. These regions are broadly comparable in turnover rates. The annual rate per 100 posts in South London, averaged over March 2011 to March 2014, was 12.34 (95% confidence interval 12.03 to 12.66). In North London, it was 12.05 (11.63 to 12.48).

There is a notable increase in turnover with time (Graph 2). This is statistically significant ($p < 0.001$) and the North London increase is statistically faster than the South London one ($p = 0.004$, from a multilevel Poisson regression). However, there is no evidence that any single trust deviates from this general upward trend.



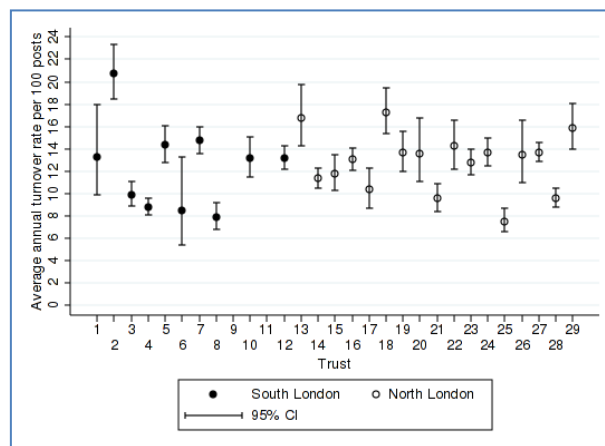
Graph 2 Quarterly turnover rate of adult nurses 2011-2013

The trend over time shows some seasonality, with the 2nd and 3rd quarters (April to September) usually having higher turnover than the 1st and 4th (October to March). This is statistically significant when included in the Poisson regression as a sinusoidal wave, though this made almost no change to the main time trend and the South-North difference.

4.3.2 Does the turnover rate differ by employing organisations as inner or outer London Trusts?

We found it difficult to classify all trusts as either inner or outer London (definitions attracting a differential high cost area supplement to nurses 'salary[NHS Staff Council 2015]) as some provide services in both inner and outer London. Some trusts were therefore classified as a mix of the two. We do not know for individual nurses whether they were in receipt of high cost area supplements.

The regional difference in turnover rate is much smaller than the differences between trusts, which was greater than could be expected just from statistical fluctuation (Graph 3 and table 4.1). This either means some trusts as organisations were retaining nurses more than others, or that they have quite different nurses and nursing posts, or both. Multivariate analysis, given below, sought to separate these.



Graph 3 Average annual turnover rate of adult nurses by Trust

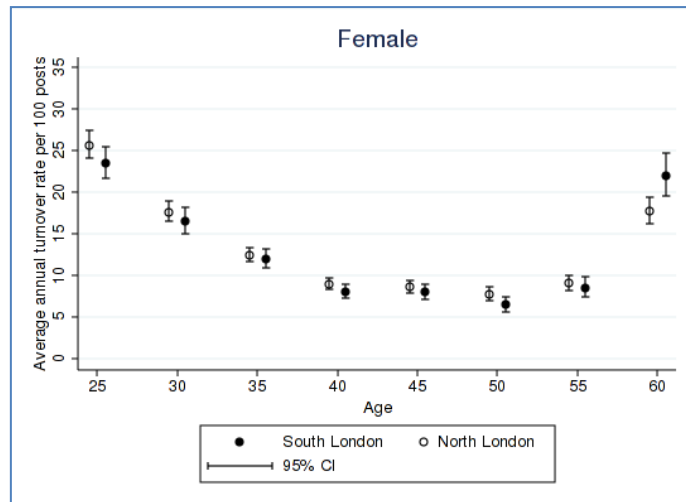
These (Table 41.1) are the basic aggregated turnover rates (and 95% confidence intervals) by trust characteristics, across all trusts and times:

| Trust characteristics | Leavers | | Leavers within a year | | Leavers within 6 months | |
|-----------------------------|---------------------------|---------------------------|------------------------|------------------------|-------------------------|------------------------|
| | South London | North London | South London | North London | South London | North London |
| All trusts | 12.34 (12.03 to 12.66) | 12.05 (11.63 to 12.48) | 2.46 (2.32 to 2.60) | 2.32 (2.14 to 2.52) | 0.88 (0.80 to 0.97) | 0.80 (0.70 to 0.92) |
| Outer | 11.00 (10.47 to 11.55) | 11.74 (11.05 to 12.48) | 2.11 (1.88 to 2.36) | 2.25 (1.95 to 2.59) | 0.83 (0.69 to 0.99) | 0.75 (0.59 to 0.96) |
| Inner | 13.28 (12.79 to 13.80) | 11.27 (10.63 to 11.95) | 2.65 (2.43 to 2.88) | 1.81 (1.56 to 2.09) | 0.88 (0.76 to 1.03) | 0.55 (0.42 to 0.72) |
| Mix | 12.43 (11.85 to 13.04) | 13.56 (12.72 to 14.46) | 2.57 (2.31 to 2.86) | 3.16 (2.76 to 3.62) | 0.92 (0.77 to 1.10) | 1.24 (1.00 to 1.54) |
| Hospital only | 12.66 (12.24 to 13.10) | 13.29 (12.61 to 14.01) | 2.52 (2.33 to 2.72) | 3.11 (2.79 to 3.48) | 0.88 (0.78 to 1.01) | 1.15 (0.96 to 1.38) |
| Hospital + Community | 12.21 (11.67 to 12.78) | 11.54 (10.94 to 12.18) | 2.45 (2.21 to 2.72) | 1.85 (1.61 to 2.11) | 0.82 (0.69 to 0.98) | 0.60 (0.48 to 0.76) |
| Community only | 11.33 (10.53 to 12.19) | 10.12 (9.13 to 11.20) | 2.23 (1.88 to 2.63) | 1.58 (1.22 to 2.05) | 0.98 (0.76 to 1.26) | 0.45 (0.28 to 0.74) |

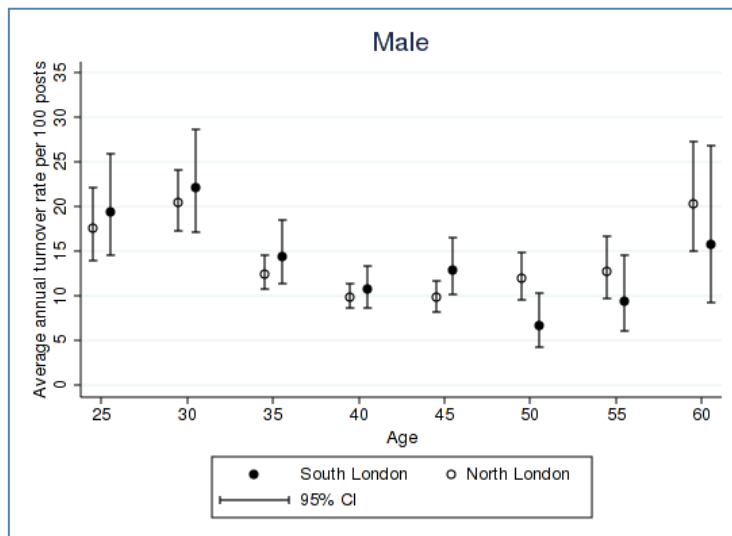
Table 4.1 Basic aggregated turnover rates by trust characteristics

4.3.3 Does the turnover rate differ by demography: gender, age band, ethnicity?

Looking at nurse characteristics, there is a U-shaped age-sex relationship, where the youngest and oldest nurses are most likely to move on, which is more marked for female than male nurses (graph 4 and 5). Here, it does not make sense to consider leavers within a year or 6 months because this will be more likely in the youngest age band by definition.

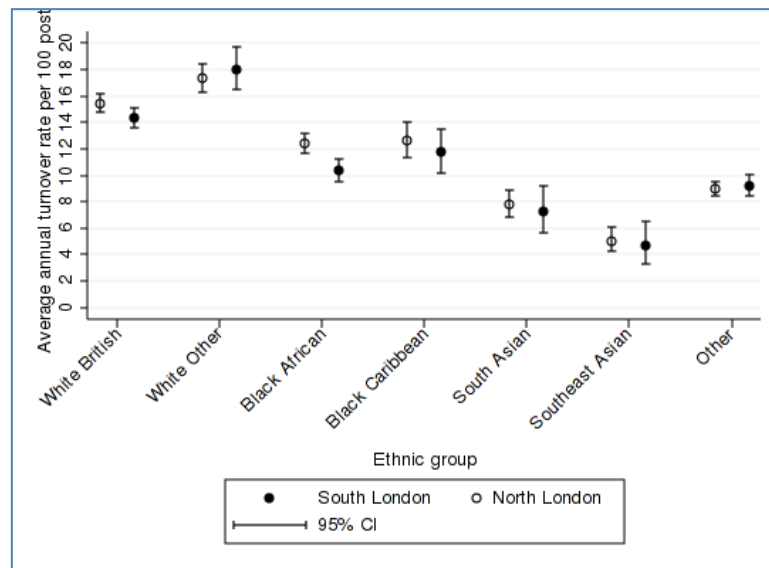


Graph 4 Average annual turnover rate of female adult nurses by age band



Graph 5 Average annual turnover rate for male adult nurses by age band

Ethnic differences are apparent which are quite consistent for South and North London. Turnover is highest in the “White Other” group, followed by “White British” (graph 6).

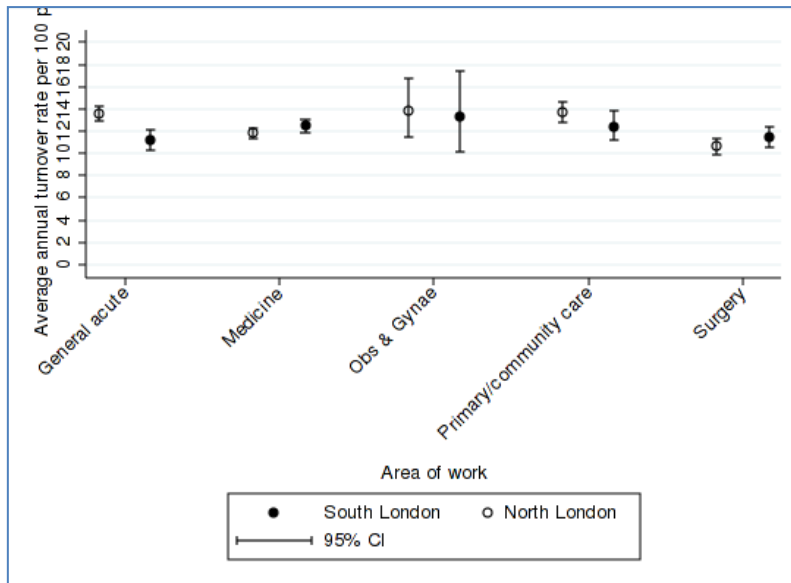


Graph 6 Average annual turnover rate of adult nurses by ethnic group

4.3.4 Does the turnover rate differ by work characteristics: full or part time working, or area of work?

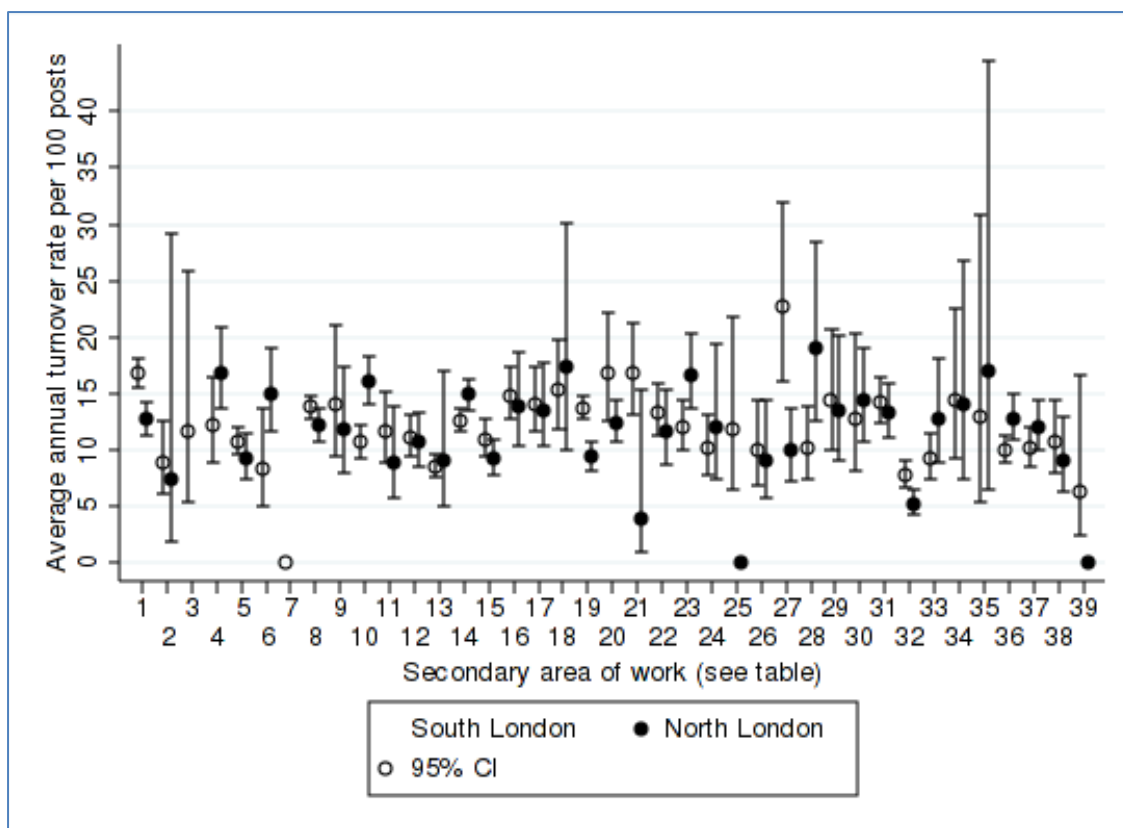
There was a small but statistically significant difference between full- and part-time posts in South London, with full-time nurses turnover rate of 11.92 (95% confidence interval 11.45 to 12.40) and part-time nurses 12.59 (11.65 to 13.61). This was similar though more pronounced in North London, with full-time rate 12.08 (11.74 to 12.43) and part-time rate 13.61 (12.84 to 14.43). Full-time posts are more common in the younger age bands, who are more likely to leave, so adjusting for age band makes the full/part-time differences even larger, with a rate ratio of 0.91 (0.86 to 0.96) becoming one of 0.80 (0.76 to 0.85).

Area of work is classified in the NHS in the National Workforce Data set (NWD) into broad “primary” categories, then more detail in secondary and tertiary areas (HSIC 2013). For this analysis, we compare the primary categories: general acute, medicine, obstetrics & gynaecology, primary care (which includes community nurses) and surgery. General acute is used as the baseline category to compare others to; medicine and surgery have significantly lower turnover rates (graph 7). We also adjusted for pay band, as there are some differences in the pay band distribution among these primary areas of work (it should be borne in mind that the primary areas are heterogeneous collections of posts and settings). This did not change the differences among the primary areas substantively.



Graph 7 Average annual rate of turnover of adult nurses by NWD primary area of work

The NWD secondary areas of work (of which 39 are relevant to this analysis and have sufficient numbers of nurses to allow reasonably precise estimates of turnover rates) are shown below in Graph 8 .



Graph 8 Average annual rate of turnover of adult nurses by NWD secondary area of work

| Code in graph | Area of work | Code in graph | Area of work |
|---------------|-------------------------------------|---------------|--------------------------------|
| 1 | Accident and Emergency | 21 | Medical Oncology |
| 2 | Anaesthetics | 22 | Medicine |
| 3 | Audiological Medicine | 23 | Neurology |
| 4 | Cardio-thoracic Surgery | 24 | Neurosurgery |
| 5 | Cardiology | 25 | Obstetrics and Gynaecology |
| 6 | Clinical Haematology | 26 | Ophthalmology |
| 7 | Clinical Neurophysiology | 27 | Pain Management |
| 8 | Community Health Services | 28 | Palliative Medicine |
| 9 | Dermatology | 29 | Plastic Surgery |
| 10 | Elderly Care Medicine | 30 | Primary Care |
| 11 | Endocrinology and Diabetes Mellitus | 31 | Rehabilitation |
| 12 | Gastroenterology | 32 | Renal Medicine |
| 13 | General Acute | 33 | Respiratory Medicine |
| 14 | General Medicine | 34 | Rheumatology |
| 15 | General Surgery | 35 | Stoma Care |
| 16 | Genito Urinary Medicine | 36 | Surgery |
| 17 | Gynaecology | 37 | Trauma and Orthopaedic Surgery |
| 18 | Infectious Diseases | 38 | Urology |
| 19 | Intensive Care | 39 | Wound Management |
| 20 | Intensive Care Medicine | | |

Table 4.2 Codes of NWD secondary area of work used in graph 8

Below, the South London results alone are ranked in terms of rate for different areas of work:

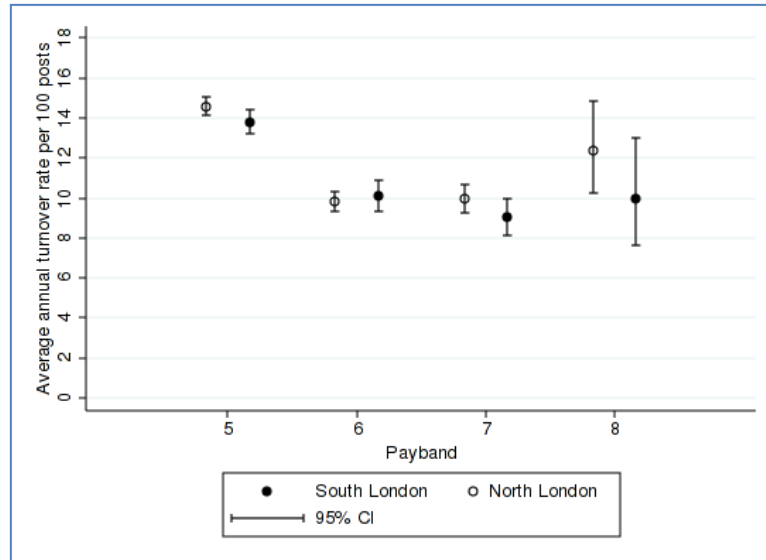
| Area of work | Annual turnover rate per 100 posts |
|-------------------------------------|---|
| Medical Oncology | 3.86 (0.97 to 15.35) |
| Renal Medicine* | 5.27 (4.25 to 6.54) |
| Anaesthetics | 7.48 (1.89 to 29.51) |
| Endocrinology and Diabetes Mellitus | 8.94 (5.73 to 13.95) |
| Urology | 9.05 (6.27 to 13.05) |
| Ophthalmology | 9.20 (5.82 to 14.52) |
| General Acute | 9.20 (4.98 to 16.97) |
| General Surgery* | 9.21 (7.78 to 10.90) |
| Cardiology* | 9.25 (7.46 to 11.48) |
| Intensive Care* | 9.40 (8.15 to 10.83) |
| Pain Management | 9.95 (7.21 to 13.74) |
| Gastroenterology | 10.73 (8.59 to 13.42) |
| Medicine | 11.64 (8.78 to 15.43) |
| Dermatology | 11.86 (8.06 to 17.45) |
| Neurosurgery | 12.01 (7.41 to 19.46) |
| Trauma and Orthopaedic Surgery | 12.05 (10.01 to 14.51) |
| Community Health Services | 12.17 (10.81 to 13.71) |
| Intensive Care Medicine | 12.39 (10.68 to 14.37) |
| Accident and Emergency | 12.72 (11.41 to 14.18) |
| Respiratory Medicine | 12.79 (9.00 to 18.19) |
| Surgery | 12.80 (10.93 to 14.99) |
| Rehabilitation | 13.27 (11.06 to 15.93) |
| Plastic Surgery | 13.58 (9.16 to 20.12) |
| Gynaecology | 13.63 (10.38 to 17.90) |
| Genito Urinary Medicine | 13.94 (10.36 to 18.77) |
| Rheumatology | 14.06 (7.40 to 26.72) |
| Primary Care | 14.36 (10.85 to 19.02) |
| General Medicine* | 14.87 (13.55 to 16.31) |
| Clinical Haematology | 14.97 (11.77 to 19.04) |
| Elderly Care Medicine* | 16.10 (14.05 to 18.45) |
| Neurology* | 16.55 (13.56 to 20.19) |
| Cardio-thoracic Surgery* | 16.97 (13.69 to 21.03) |
| Stoma Care | 17.02 (6.52 to 44.41) |
| Infectious Diseases | 17.33 (9.96 to 30.14) |
| Palliative Medicine* | 18.97 (12.61 to 28.52) |

Table 4.3. Turnover rate by NWD secondary area of work by rank order in South London

* = significantly lower or **higher** than the overall South London figure of 12.43

4.3.5 Does the turnover rate differ by professional characteristics – newly qualified, pay band, new to the NHS, job role?

Nurses in pay bands 6 and above have a significantly lower rate of turnover than those paid at band 5 (graph 9). It is correlated with age, so once we adjust for age (Poisson regression), the pay band is still significant but with a reduced effect. Splitting band 5 roughly in half at increment point 300 produces similar results, those nurses in the lower band 5 have significantly higher turnover rate than the others.

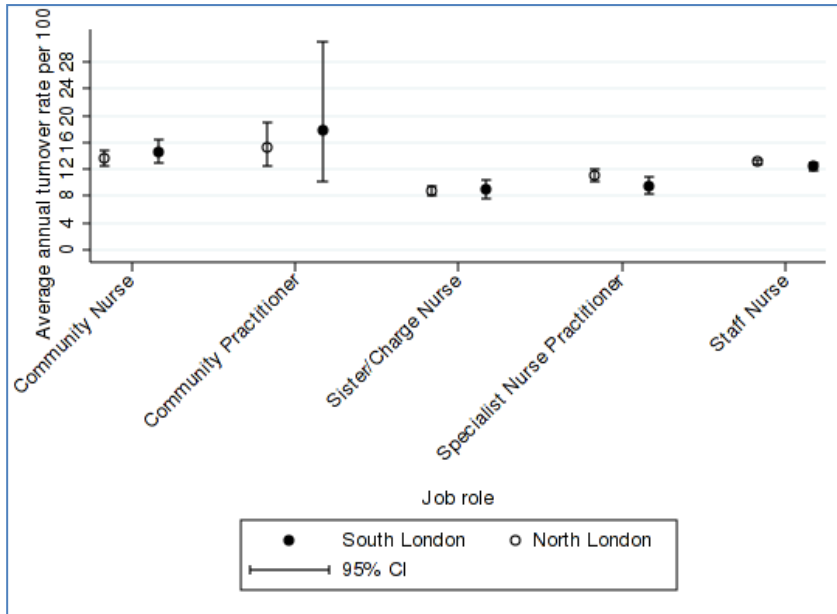


Graph 9 Average annual turnover rate of adult nurses by pay band

Comparing job roles also highlights some differences in turnover which are partly due to age and pay bands; these three aspects of the individual nurse's characteristics are intertwined. In this comparison, we use community nurses as the baseline group to compare others to. Considering job role on its own, the sister/charge nurses, specialist nurse practitioners and staff nurses have significantly lower turnover rates than the community nurses, while staff nurses are not statistically significantly different (graph 10).

However, staff nurses are more often younger than the other roles, and specialist nurse practitioners more often older. After adjusting for age band, the differences with sister/charge nurses and specialist nurse practitioners were slightly reduced and the difference with staff nurses slightly increased. Significance was not altered.

Pay band is also involved, with community practitioners, specialist nurse practitioners and sister/charge nurses rarely (all less than 4%) in band 5, while the other groups have more than half in band 5. After adjusting for pay band, community practitioners have significant higher turnover than community nurses, while sister/charge nurses and staff nurses have significantly lower turnover, and specialist nurse practitioners are not significantly different.



Graph 10 Average annual turnover rate in adult nurses by job role

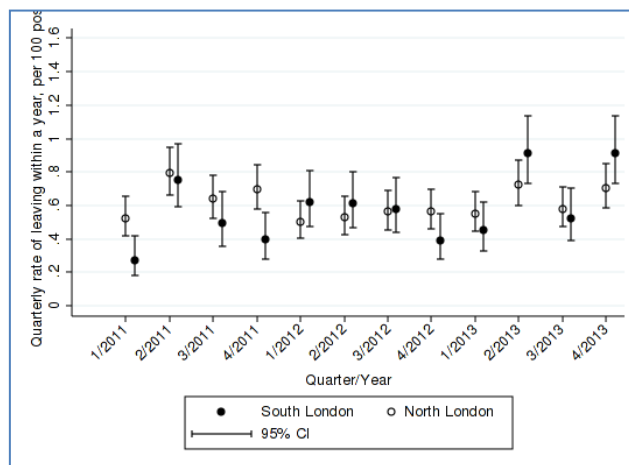
We could not obtain information on qualification date and the date of joining the NHS was only available for leavers (and missing for a substantial minority of them), so we could not meaningfully address these aspects of the research question.

4.3.6 What is the rate of adult nurses leaving within 6 months and between 7-12 months of taking up post in an organisation?

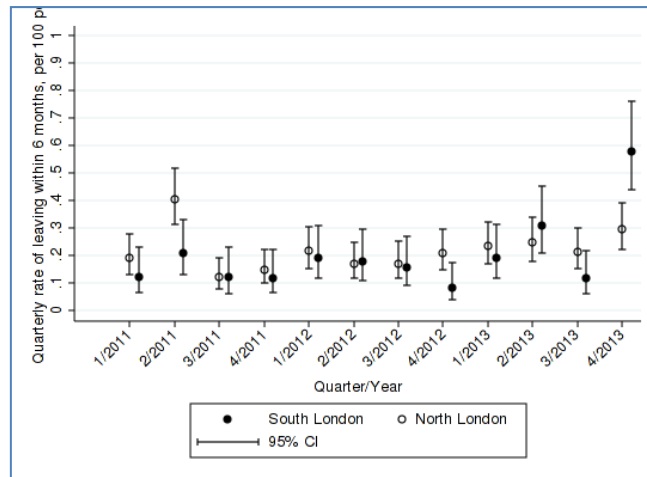
North and South London do not differ in terms of the rate of nurses leaving within *one year* of joining (graph 11). The rate per 100 posts in South London was 2.32 (95% confidence interval 2.15 to 2.52), and in North London was 2.46 (2.32 to 2.60).

North and South London do not differ in terms of the rate of nurses leaving within *six months* of joining (graph 12). The rate per 100 posts in South London was 0.88 (0.80 to 0.97), and in North London was 0.80 (0.70 to 0.92).

Some of the quarters in 2013 were characterised by unusually high rates of leavers within six months and one year, particularly in South London.



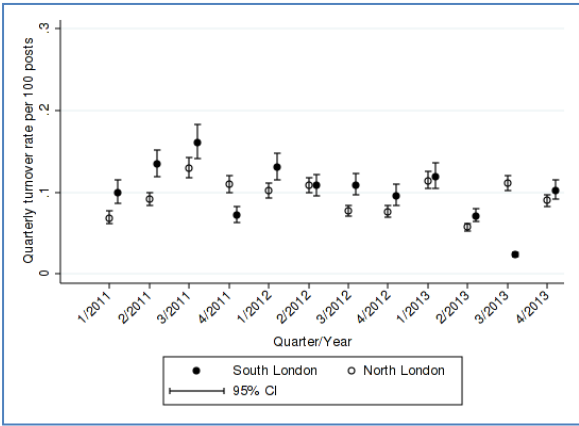
Graph 11 Quarterly rate of adult nurses leaving a post within 1 year



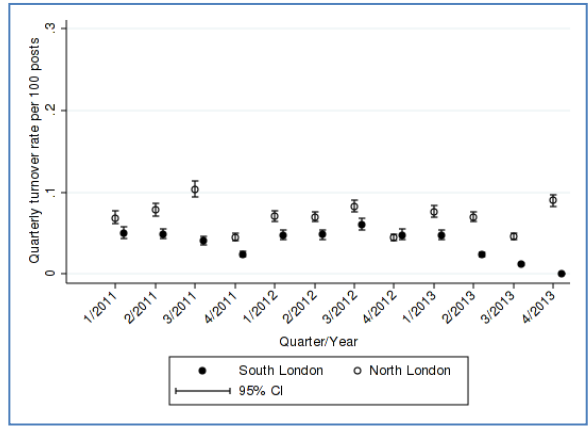
Graph 12 Quarterly rate of adult nurses leaving a post within 6 months

4.3.7 What are the reasons for leaving an organisation, and what percentage is for positive reasons compared to negative reasons?

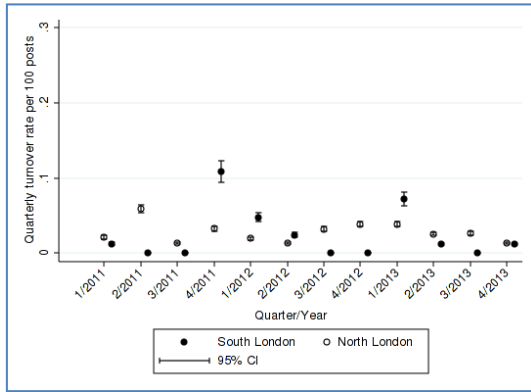
The graphs below show the quarterly rate of nurses leaving because they are dismissed (graph 13), contracts expired (graph 14), made redundant (graph 15), retired (graph 16) or resigned (graph 17). The resignations and then retirements are the largest groups. There are some clearly anomalous quarters but in terms of overall trends, the only time trend that was statistically significant was the increase in nurses resigning, and the only North-South difference that was significant was in contractual reasons, where there were fewer in South London in all but one quarter.



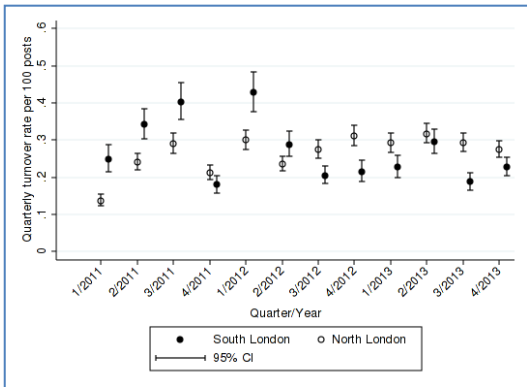
Graph 13 Rate of adult nurses dismissed 2011-2013



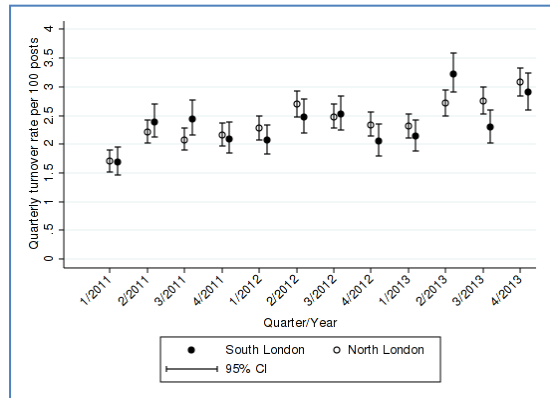
Graph 14 rate of adult nurses leaving as the contract had ended



Graph 15 rate of adult nurses made redundant



Graph 16 rate of adult nurses retiring



Graph 17 rate of adult nurses resigning

We categorised the more detailed information on these reasons into 'happy' and 'unhappy' leavers, for example resigning for a promotion compared to resigning for work-life balance. There were 5589 'happy' out of 12668 (44%), 2578 'unhappy' (20%) and 4501 who could not be classified (36%), of whom 4425 resigned. Given the large proportion recorded as resigning without further reasons given, we first considered whether these unclassifiable leavers (effectively, 36% missing data) were in some way different to those who did have reasons recorded, which would indicate potential bias. They were slightly older (2 years median) and had slightly longer service in their post (1 year median) but the largest difference was between trusts, which ranged from 4% of resigning staff with no reason to 99% of resigning staff. This indicates different administrative practices between organisations in how much detail is recorded, and suggests that we could not look for differences between the happy or unhappy leavers in terms of trust or probably post characteristics, and as we know the difference will be affected more by trust than by personal characteristics, we cannot draw any firm conclusion with a high risk of biased and potentially misleading conclusions.

We considered whether nurses had left for other jobs in the NHS, which is less concerning for HR planning and investment than leaving the health service completely. It should be borne in mind that many nurses have more than one post, and so leaving one part-time post to work shorter hours could be regarded either as leaving for another NHS post, or leaving for no post. With complexities like this, the classification is not entirely meaningful. Also, of the 12,668 leavers extracted from the system (some of whom are excluded from subsequent analyses for various reasons of data quality and relevance), 48% had no recorded destination. In analyses with missing data, this is a very high proportion to have unknown, and so we had to consider whether there was any evidence that these unknown leavers were different in some way from those whose destinations were known, because this could bias any analysis that simply ignored the unknowns. They were slightly younger on average, but only by a year, and more likely to be male, but only by a difference of 5%. The largest influence on unknown destination seems to be the trust, with individual trusts varying from 12% unknown to 86% unknown. This suggests that there are simply different administrative practices contributing to the data and we could not draw any conclusion from it when comparing trust characteristics. We then considered evidence of bias by missing data between different characteristics of the post. Unknown destination was more likely among staff nurses and community nurses than the other job roles, though there was no noticeable difference in primary area of work. This means that there is potential bias in how the destination is recorded at both trust and post level. Unfortunately it would be unwise to draw any conclusions about determinants of leaving for other NHS posts; the data are simply not complete enough.

4.4 Concluding Comments

We have data from South and North London. These regions are broadly comparable in turnover rates.

The turnover rate increased with time, rising sharply in 2013 and this is statistically significant. There is no evidence that any single trust deviated from this general upward trend. Some of the quarters in 2013 were characterised by unusually high rates of leavers within six months and one year, particularly in South London.

The regional difference in turnover rate is much smaller than the differences between trusts, which were greater than could be expected just from statistical fluctuation.

Looking at nurse characteristics, there is a U-shaped age-sex relationship, where the youngest and oldest nurses are most likely to move on, which is more marked for female than male nurses.

Ethnic differences are apparent which are quite consistent for South and North London. Turnover rate is highest in the “White Other” group, followed by “White British”.

Part-time nurses have a significantly higher turnover rate than full time nurses, even when adjusted for age.

The work areas with significantly higher adult nurse turnover rates in South London are general medicine, elderly care medicine, neurology, cardio-thoracic surgery and palliative medicine. These may be the work areas that Trusts should prioritise for more in depth analysis to inform their nursing retention strategies.

We intended to analysis in more depth the reasons for leaving posts, particularly in relation to positive and negative reasons, and whether nurses were leaving for other NHS posts or elsewhere. Unfortunately we were unable to do so due to the large amount of missing data. We suggest this area that Trusts might consider targeting to improve the data capture for in-depth analysis and action.

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5 The key issues and local evidence of best practices to reduce turnover from senior nurse and human resources managers' perspectives

5.1 Introduction

We aimed to identify key issues and local evidence of best practices in South London that might reduce the turnover in adult nurses through telephone or face to face interviews with Directors of Nursing and Directors of Human Resources (or nominated others). The interviews focused on three questions:

- In your view, what factors contribute to adult nurse turnover rates?
- In your view, what strategies could best reduce the rate?
- Have you examples from your Trust of best practices in reducing rates that you could share with other trusts?

We were able to interview 20 senior managers in seven Trusts (table 5.1) across South London. Two of the Trusts also provided adult nursing in the community.

| | Numbers | |
|--------------------------------|--------------|--------------|
| | Inner London | Outer London |
| Senior nurse managers | 8 | 4 |
| Senior human resource managers | 4 | 4 |

Table 5.1: Number and type of individual senior manager interviews

With permission, notes or digital recordings were made during the interviews. Each was then written up, removing individual identifying features, giving each a study identification code referring only to type of Trust (inner or outer London) and type of senior manager (nurse or human resources). Each was thematically analysed close to the time of the interview. Through an iterative analytical process, themes were tested and sense checked in subsequent interviews. Examples of initiatives and actions to reduce nurse turnover are identified by Trust , with permission , and used in this report.

5.2 Findings: overarching context

Turnover as a positive but problematic concept

Many participants started by commenting that a degree of movement in all staff groups was to be expected and it was healthy for a workforce as it presented the opportunity to bring new people with new ideas, energies and skills to teams. However, they were also conscious that there was a point at which turnover rates became problematic to an organisation. Most of the participants recounted that the current increase in rates of adult nurse turnover had become apparent in their Trust in 2013 /early 2014.

Increased demand for adult nurses

They were unanimous that the overarching cause for higher rates of turnover was the increased demand for adult nurses in hospital Trusts in London and England wide - *“Nurses have many choices in what job they do and where they work at the moment”*.

They pointed to key drivers to this increased demand for nurses as:

1. The actions required in Trusts following the publication of the Mid-Staffordshire public enquiry and the Berwick review on patient safety (DH2013, 2014),
2. The actions required on the publication of national guidance on safe nurse staffing levels for adult inpatient wards (NICE2014)
3. The increased numbers of nurses required for expanding /new Trust services or changing skill mixes within hospital care.

In the context of burgeoning demand participants described factors that ‘pulled’ nurses out of their jobs to others that were seen as more attractive –and those that ‘pushed’ them to leave.

Recruitment and retention as a priority to reduce cost and human consequences

In some Trusts there was a view that the nurse turnover rates were stabilising but that didn’t alter their prioritising of activities which retained adult nurses. Reasons articulated for this included:

- The need to retain experienced nurses in their workforce, and grow their senior nurse cohort and successors,
- To keep vacancy rates as low as possible because of the consequences for colleagues (see *‘the vicious circle’* below),
- Reduce the costs of use of agency nurses to cover vacancies ,
- Reduce the costs of recruitment and induction to their Trust.

Most reported the interconnectivity of recruitment activities with retention rates – *“good recruitment of the right nurses for the right jobs is the starting point to keeping them “*. Many referred to this interconnectivity in certain circumstance as leading to a *“vicious circle”* where vacant nursing posts combined with failure/slowness to recruit led to an over reliance on agency staff and perceived more responsibility for remaining permanent staff who then decide to leave.

5.3 Findings: Issues and potential solutions to reduce turnover in South London

We now turn to the issues with adult nurse turnover, potential solutions and the examples in South London of innovation in addressing them. In reporting our findings we first discuss the overarching strategy and leadership in Trusts before looking how Trust’s use information in identifying trends, issues and solutions. We then turn to consider three types of factors

- 1) Remuneration and the cost of living,
- 2) The type of nursing work and career development
- 3) The work environment.

Senior nurses tended to consider the nursing workforce as heterogeneous and divided them into sub groups to consider these factors. Mostly commonly they grouped them by career (e.g. newly qualified, junior ward managers) and by life stage (e.g. young and at the start of their working careers, having a young family ,close to retirement) .

We present examples of solutions and initiatives from trusts with contact details in boxes in each section. It should be noted that there may be more or similar examples in other Trusts but these were the ones we were made aware of.

5.3.1 Strategy and leadership in the retention of nurses

All the Trusts had workforce development strategies with Trust Board level oversight and participated in the NHS staff survey 2014 (Picker Institute Europe/NHS 2014). Some reported strategies written specifically for the nursing workforce. Most participants described structures within their organisations in which there was co-ordination of effort and oversight across different departments, professional and occupational groups. Often this included a specific recruitment and retention committee or similar with defined work streams – often one of these specifically on nursing. The Chief Nurses/Directors of Nursing were the leaders in addressing issues related to nursing but many also had deputies or assistant directors of nursing who might lead on it or a part of it for example in roles linked more broadly to nurse development for the Trust. Some Trusts had specialist senior nurse roles working only on aspects of recruitment and retention (see Box 5.1). One Trust had also re-organised so that the HR teams aligned to professional groups such as nursing rather than services or divisions (see Box 5.1)

Head of Nursing (Workforce) - Chief Nurse Office [Neil Webb] and Matron/lead nurse for recruitment [Michele Gardiner] Guy's and St Thomas' Foundation Trust contact Neil.Webb@gstt.nhs.uk and Michele.J.Gardner@gstt.nhs.uk for more information

Head of Nursing and Midwifery Recruitment and retention [Ann Kelly] Epsom & St Helier's University Hospitals NHS Trust contact Ann Kelly for more information E: ann.kelly@esth.nhs.uk

Head of Nursing – Workforce [Paul Silke] St. Georges University Hospitals NHS Foundation Trust contact Paul.Silke@stgeorges.nhs.uk

Assistant Director of Nursing –staffing – [Debbie Hutchinson] Kings College Foundation NHS Trust contact for more information Email: debbiehutchinson@nhs.net

HR teams aligned to nursing rather than services areas/divisions Guy's and St Thomas' Foundation Trust for more information contact James Limehouse project manager James.Limehouse@gstt.nhs.uk

BOX 5.1 EXAMPLES OF SPECIALIST SENIOR NURSE ROLES FOR RECRUITMENT AND RETENTION AND SPECIALIST HR TEAMS FOR NURSING RECRUITMENT AND RETENTION

5.3.2 Using information to understand the issues in the nursing workforce

Many participants highlighted the need for Board members and those in management posts at all levels in the organisation to understand the nursing workforce and the trends within it. Most reported the Chief Nurse/Director of nursing taking specific formal reports and recommendations to the Trust Board on the nursing workforce. Many described different ways in which data and information was being reported throughout their organisation to help managers understand and act

on issues related to retention of nurses. This ranged from presenting data at ward level to ward managers (see box 5.2) to more detailed investigation and analysis of the reasons for nurses leaving their posts (box 5.3). Many were working at improving the quality and depth of their analysis of their workforce data.

Ward dashboard reports on workforce produced for ward managers by the human resources dept. at Croydon Health Services NHS Trust. For more information contact Michael Burden, Director of Human Resources and Organisational Development Michael.Burden@croydonhealth.nhs.uk

BOX 5.2 EXAMPLE OF WORKFORCE DATA AT WARD LEVEL

Reasons for leaving analysis, reporting and planning regarding reasons for nurses leaving jobs separated in to 'happy' (i.e. with positive reasons such as career progression) and unhappy leavers (i.e. negative reasons about the job) to identify issues and plan to address them in St. Georges University Hospitals NHS Foundation Trust contact for further information Wendy Brewer Joint Director of Workforce & Organisation Development, St Georges Healthcare NHS Trust and St Georges University of London E: wendy.brewer@stgeorges.nhs.uk.

Exit interviews and retention interviews – a human resource staff member assigned to undertake exit interviews with staff leaving to improve both the volume and quality of information gathered, and also undertake interviews at 100 days from starting a post to understand any issues and any intentions to leave and address those. Kingston Hospital NHS Trust contact for further information Terry Roberts - Director of Workforce Terry.Roberts@kingstonhospital.nhs.uk

BOX 5.3 EXAMPLES OF MORE DETAILED INVESTIGATION AND ANALYSIS OF REASONS FOR LEAVING JOBS

The third set of activities related to information on the issues related to nursing workforce were the means for engaging and communicating with nurses – often part of the broader staff engagement and communication strategies. These were aimed at both identifying problems and also potential solutions. Some examples which particularly target at nursing workforces are given in Box 5.4.

Listening into Action (<http://www.listeningintoaction.co.uk/>) methods, which aims for greater staff engagement in supporting them to work differently, valuing their ideas, – used with nurses in Croydon Health Services NHS Trust contact Michael Fanning, Director of Nursing, Midwifery and Allied Health Professionals, Email: michael.fanning@croydonhealth.nhs.uk And St. Georges University Hospitals NHS Foundation Trust contact Liz Woods, Listening into Action project manager for more information email - liz.woods@stgeorges.nhs.uk

Opportunity for direct electronic contact with the Chief Nurse – “Ask Eileen” intra-net site for nurses to contact directly the chief nurse, Eileen Sills, Guy's and St Thomas' Foundation Trust. Contact for more details Neil Webb Head of Nursing (Workforce) - Chief Nurse Office email Neil.Webb@gstt.nhs.uk

BOX 5.4. EXAMPLES OF SENIOR MANAGEMENT ENGAGEMENT ACTIVITIES WITH THE NURSING STAFF

5.3.3 Remuneration and cost of living

All participants pointed to the context of the high cost of living in London, in the context of a national decision not to award a 1% pay rise to NHS staff, and in particular the issue of housing affordable to nurses (and other health care staff).

Participants were conscious that remuneration was one factor in the attractiveness or less attractiveness of posts. Most were clear that it was only one factor but an important one. Solutions to problems were often interconnected to the other aspects of nurses working lives such as career development. Under this topic the following were discussed: high cost area supplements, differently graded posts, rates of pay for agency staff. We touch on each of these in turn.

High cost area supplements was one issue discussed. The senior managers described to the attraction of similar nursing posts in London Trusts that could offer the Inner London high cost area supplement (20% of basic salary subject to a minimum £4117 and maximum £6,342) compared to that for outer London (15% of basic salary subject to a minimum payment of £3,483 and a maximum payment of £4,439) - *“yes of course that two thousand pound a year difference means a lot in take home pay when it’s only a short bus ride difference to another hospital up the road”*. For those working in designated outer London areas, they were conscious of the draw of a higher supplements but talked of other ways in which to make nursing posts attractive in their Trusts, linked to for example career development. One Trust which had sites which were inside and outside the areas for attracting supplements had taken the decision to give all staff the higher supplement irrespective of place of work (see Box 5.5).

Higher pay for nurse by temporary staffing agencies. A number of participants discussed the problem of rates of pay for agency nurses as being often higher than those of nurses on permanent contracts and therefore becoming a draw to nurses in their Trust. *“So anecdotally we’ve heard that the agency nurses come and talk to their colleagues about their pay and are signing up people with the agencies ...we have a very good in-house bank for nurses but they’ve seen their numbers drop”*. A number of respondents argued that there should be a sector wide agreement on a ceiling to be paid for agency staff to try and manage both the cost but also the pull of such wages. One participant described local HR events modelling the losses in the long term to their staff if they left the NHS to work for agencies e.g. loss of NHS pension over time (see Box 5.5).

Grading of clinical nurse specialist posts. Some reported that clinical nurse specialist posts in some tertiary specialities were more highly graded in Trusts outside of London or required less evidence of qualifications or expertise than in the London tertiary centres. They reported this pulled nurses away from their London Trusts, particularly those nurses with less experience who might be the *‘supply pipeline’* or successors to those experienced clinical nurse specialists nearing retirement. *“ So they are kept at band 5 because they haven’t got all the courses the unit says they have to have for band 6 but they can go out of London and get the same job at band 6 without needing this and that expected here.”* Again solutions were offered linked to career development and being able to offer further training and qualifications.

Grading within band 5 posts. The largest groups of nurses are in the Band 5 salary scale and this is one group in which senior nurses expected movement as these were those new to nursing and often at early stages of their career. One issue raised was how to differentiate between newly qualified nurses and those who were more competent and capable, both to attract and retain them. One Trust reported that they were one of a number of Trusts, looking at using flexibilities in the Band 5

pay scale to create a differential between newly qualified (and junior) staff nurses from the more capable senior staff nurses. This was described as creating a '5.5' grade (see Box 5.5).

Affordable Housing. Participants pointed to the attractiveness, particularly to those with families and in mid-career, of moving out of London to work and live in areas of more affordable housing. There was also a view expressed that many younger people come to London to train and work as nurses then move back to their 'home' region as they get older and that factors such as affordable housing contribute to those decisions. Some Trusts were reported to have single accommodation still to rent to its workforce but it was of small quantities and tenancy was time limited. A view point was put forward that affordable housing for key health service staff was a sector wide issue and solutions went beyond an individual Trust. A suggestion was made that it was an issue for all key staff in any Borough and needed to be raised with Local Authorities and other London wide bodies such as the Greater London Authority.

Ensuring the same high cost area supplements were the same across all Trust sites and not different at different sites. Further information Epsom and St. Helier University Hospital NHS Trust Kevin Croft, Director of People and Organisational Development Kevin.croft@esth.nhs.uk

Creating a 5.5 band staff nurse grade for further information contact Debbie Hutchinson, Assistant Director of Nursing King's College Hospital NHS Foundation Trust Email: debbiehutchinson@nhs.net

Demonstrating the financial and other consequences long term in working for a nursing agency at St. Georges University Hospitals NHS Foundation Trust contact for further information Director of Human Resources Wendy Brewer wendy.brewer@stgeorges.nhs.uk.

BOX 5.5. EXAMPLES OF ASPECTS OF REMUNERATION

We turn now to the type of nursing work and progressing nursing career.

5.3.4 Progressing a nursing career and the type of nursing work

In this section we discuss the issues and perceived solutions by segmented groups of nurses: the newly qualified, the new to the UK, the more senior staff nurses, clinical nurse specialists, junior ward management roles.

Newly qualified nurses and preceptorship The senior nurses were aware of the risks of newly qualified nurses not being supported into the working world of nursing and leaving both their jobs and the profession of nursing. They were conscious of the Nursing and Midwifery Council guidelines for preceptorship for newly qualified nurses (NMC 2006). All Trusts involved pointed to the well-established preceptorship programmes supported by the Chief Nurse/Director of Nursing's team. As these were run in every Trust we have not given examples and contact details specifically for these although it was apparent that there were variations between Trusts. For example some ran one or two year courses in which the nurses had specific training days, joined courses and completed competency booklets while others were shorter with less frequent group contact.

Newly qualified nurses and opportunities to experience a range of posts and specialities. Senior nurses were aware that those new to nursing were likely to want to gain a range of experience and often moved on quite quickly from first jobs. One Trust had developed and run a rotation programme for newly qualified nurses moving to posts in three different specialities over a year. This

was designed to both help address nurses' desire to gain different experiences but within the one Trust but also to help attract nurses to work in specialities areas that they might not first consider. (See Box 5.6). A number of senior HR managers noted that retaining staff with the Trust, even if in another post , was a valuable objective and the costs of these processes needed to be minimised. One Trust reported having established processes for Band 5 nurses to move to new posts within the same Trust which treated them as a known employee rather than an outside applicant (see Box 5.6).

New to the NHS and new to London nurses At the point of the interviews (spring 2015) many were actively recruiting or considering recruiting cohorts of qualified nurses from parts of the European Union (Portugal , Spain , Greece, Romania were mentioned) or further afield such as the Philippines, India , Australia and New Zealand. All were able to discuss in detail the advantages and disadvantages of such strategies. Many voiced a preference for '*growing our own workforce*'. Many had been involved in large scale overseas recruitment of adult nurses in the early years of the new millennium and reflected how similar the situation had become– "*it's a bit deja-vu at the moment* ". They reported that in their experience the cost of acclimatising overseas nurses to the UK and the NHS was high for an organisation as was the rate of return to home countries, particularly for those from countries in close proximity. Some were conscious , particularly under the previous NMC registration system for overseas nurses, that overseas nurses might be recruited by their Trust but see it as only '*a stepping stone*' to moving to a more attractive, to them ,UK post for example to an area where there was a stronger ,established community of that nationality . Some Trusts were offering particular support to overseas nurses either in tailored group programmes, specific preceptorship or through the preceptor programmes (see Box 5.6).

One year rotation programme for newly qualified nurses Guy's and St Thomas' Foundation Trust for more information contact Michele Gardiner Matron/lead nurse for recruitment ,Michele.J.Gardner@gstt.nhs.uk or for Neil Webb , Head of Nursing (workforce) Neil.Webb@gstt.nhs.uk

Assisting Band 5 nurses to stay within the Trust and gain different experiences St. Georges University Hospitals NHS Foundation Trust contact for more information Paul Silke , head of nursing – workforce , Paul.Silke@stgeorges.nhs.uk

Programme for newly recruited overseas nurses Lewisham & Greenwich NHS Trust for more information contact Diane Cameron Nursing Education and Development Lead email diane.cameron1@nhs.net

Addressing the needs of nurses new to the NHS in a preceptorship programme Kings College Hospital Foundation Trust for more information contact David Keen Preceptorship Lead, Executive Nursing Practice Development Team, david.keen@nhs.net

A named preceptor/senior nurse to support nurses from overseas St. Georges University Hospitals NHS Foundation Trust contact for more information Paul Silke , head of nursing – workforce , Paul.Silke@stgeorges.nhs.uk

BOX 5.6 EXAMPLES OF ACTIVITIES FOCUSED ON THOSE NEW TO NURSING AND NEW TO THE NHS

Building a nursing career in a speciality and leadership roles

Senior nurses were conscious that nurses could be pulled to other Trusts to gain specific speciality experience or sometimes because they believed that '*the grass was greener*' in that part of a speciality . Some senior nurses pointed for example to the creation of a smaller number of trauma

units across London meant that nurses following careers in emergency nursing would be attracted to those units and away from those Trusts not so designated. *“Certainly I was talking to one of our A & E nurses last week who was leaving and saying it was experience in a unit with the helicopter emergency services ... which we can’t offer . ”* This was perhaps one of the unintended consequences of pan-London models of service delivery. Some participants speculated as to whether there could be sector wide opportunities for staffing in such specialities so there were nursing jobs that included rotation to specialist centres and out to other secondary care settings. A number of senior nurses were considering how rotation of work experience into community settings might be beneficial to the nurses, services and patients. In individual Trusts, some had established job rotation schemes for experienced staff nurses in specialist divisions (see Box 5.7).

Rotational post scheme in cardiac medicine division Guy’s and St Thomas’ Foundation Trust contact for further information Neil Webb Head of Nursing (Workforce) - Chief Nurse Office contact Neil.Webb@gstt.nhs.uk

Rotational post scheme in theatre division St. Georges University Hospitals NHS Foundation Trust contact for more information Paul Silke , head of nursing – workforce , Paul.Silke@stgeorges.nhs.uk

BOX 5.7 EXAMPLES OF DIVISIONAL ROTATIONAL JOB SCHEMES

It should be noted that many participants also pointed to an increased recognition in their Trust that they should be helping nurses gain experience and promotion within their organisation rather than the nurses have to change employer. Many participants described the issues of cumbersome NHS recruitment processes not geared to recruiting their own staff to different posts as in these examples *“everything including your cat’s name in a job application even if you are a nurse working for us already !”* – *“why should our own nurses have to come to an open recruitment day on their day off along with everyone else?”* Many Trusts were putting into place processes to make it less bureaucratic for their own staff to change posts within the organisations.

Succession planning for those in clinical specialist roles, ward manager roles and more senior was also frequently referred to by the senior nurses. *“Ward managers that’s a really difficult area to recruit into – million pounds budgets, twenty four hour responsibility and then they lose money because they don’t get the unsocial hours pay.”* Participants reported on professional development opportunities including leadership that were offered to help retain nurses and grow their own pool of nurses to be successors to older , more experienced nurses who were retiring particularly in leadership or management roles. These included aspiring leaders programmes targeted at those looking to have ward management careers (see Box 5.8). They were also seen as important in the development of management behaviours that encouraged nurses to remain within a post or Trust (see 5.2.5).

Are you the next Inspirational Band 7 Nurse or Midwife? – Preparing to be a Leader course King's College Hospital NHS Foundation Trust contact for more information Debbie Hutchinson Assistant Director of Nursing debbiehutchinson@nhs.net

Aspiring ward sister/charge nurse programme Kingston Hospital NHS Trust contact for further information Duncan Burton, Director of Nursing email duncan.burton@kingstonhospital.nhs.uk

Practice Development Band 6 Development Programme Kingston Hospital NHS Trust contact for further information contact Sarah Connor, Head of Professional & Practice Development Sarah.Connor@kingstonhospital.nhs.uk

Bespoke HR support programme for all band 7 nurse managers St. Georges University Hospitals NHS Foundation Trust contact for more information Paul Silke, head of nursing – workforce, Paul.Silke@stgeorges.nhs.uk

BOX 5.8 EXAMPLES OF LEADERSHIP AND MANAGEMENT SKILLS DEVELOPMENT

5.3.5 The work environment

A number of participants offered the view that '*people leave their manager not their job*' or more broadly "*they leave teams and managers not their job as such* ." Within this participants described not only that team and work environment but the manager's behaviour as something that contributed to the 'push' factors. Some made references to their staff surveys and there still being reported experiences of bullying by managers and the ways in which the Trust was addressing those issues. Many offered the view that the manager could be key factor in keeping the nurse in the post or at least in the organisation. Support for leadership and management skills development was seen to be important, such as those given in box 5.8.

Aside from the '*vicious circle*' in nurse vacancies , workload , and turnover , participants discussed the *push* from posts through the impact of the '*heaviness*' in physical and emotional labour of nursing in-patient wards. Participants discussed many factors that might contribute including: staffing levels, acuity of patients, increased volumes of people with multiple physical and mental health problems such as cognitive impairment.

In relation to the nurses themselves a couple of senior nurses speculated whether the expectations of those qualifying as nurses were not attuned sufficiently to that work in acute in-patient settings and if more could be done to address that during their training. Others focused on the need for senior staff to be alert to these pressures and ensure they listen to, respond appropriately and engage the nursing staff in developing solutions such as the examples given above in Box 5.4. The preceptorship and support activities such as those given in Box 5.6 were also cited as important in this context as were broader Trust staff well-being strategies. One Trust offered the example of investing in ward team development days in which the ward managers and their teams were given time together away from the ward to work out solutions and better ways of working (Kingston Hospital NHS Trust contact for further information Duncan Burton , Director of Nursing email duncan.burton@kingstonhospital.nhs.uk).

5.4 Conclusions

This element of the project has demonstrated the strategic focus on retaining and developing adult nurses across Trusts in South London and has offered a range of nursing specific examples to address some of the key factors which ‘push’ nurses from posts and organisations and create a ‘pull’ to remain in posts and organisations .

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6 Views from adult nurses and ward managers

6.1 Introduction

We aimed to investigate the perspective of qualified adult nurses as to factors that influenced nurses to leave their jobs and their views as to actions, factors or initiatives that might reduce the rates of adult nurses leaving their jobs.

We undertook group interviews using modified nominal group techniques (Van den Ven and Delbecq 1972). We purposively sampled types of nurses as suggested by the Directors of Nursing and the HESL steering group. This included newly qualified nurses, qualified nurses new to UK, nurses paid on Band 5, nurses paid on Band 6 and ward managers. These nurses were approached initially by the senior nurses in five NHS Trusts in south London to volunteer for the group interviews using material about the study prepared by the research team. The interviews were held in Trust premises. Some groups had been especially convened and some were inserted before or after other events/meetings for the nurses. Each interview was led by a researcher, who commenced the group interview by reiterating from the participant information sheet that the purpose was to gain the breadth of opinion, and so all viewpoints were welcomed and there did not have to be consensus. The researcher asked the group to address two questions:

- What factors influence adult nurses to leave their jobs?
- What could be done to help address those factors by senior staff in a Trust?

If the group size was large then smaller groups of 4 or 5 were formed to discuss responses and feedback into the larger group. The small group or the researcher noted responses onto flip chart and the researcher asked for clarification on points to ensure understanding. The flip charts together with the researcher's field notes were used to create a single record of each group. These were analysed thematically by two researchers. The only identifiers in these records were whether the group was in inner or outer London and if the group had any particular characteristics such as being newly qualified. The last two groups raised no new issues that had not already been raised by others suggesting that we had captured the majority of viewpoints and saturation in our data (Seale 1999).

We undertook 10 group interviews attended by 167 nurses.

| | Number of nurses | |
|---|------------------|--------------|
| | Inner London | Outer London |
| Group interviews | 7 | 3 |
| <i>Type of nurses in the group</i> | | |
| Newly qualified nurses and band 5 | 30 | 20 |
| New to the UK (band 5) | 5 | 37 |
| Nurses band 6 (junior ward managers, specialist nurses) | 3 | 19 |
| Ward managers/sisters/charge nurses | 40 | 0 |
| Community nurses | 13 | 0 |
| Total | 91 | 76 |

Table 6.1 Number and type of nurses participating in group interviews

6.2 Findings

All the groups were lively in their discussion and debate around these topics. Some held more strongly felt views than others but there was consistency of views on many of the key themes, irrespective of the Trust or type of nurse. The overall key themes for the issues, together with suggested solutions, are reported under the following headings:

- The advantages and attraction of another post ,
- Negative factors that push nurses from their jobs
 - Remuneration and the cost of living ,
 - Management practices
 - The impact of nurse vacancies
 - Working patterns, patient acuity and staffing
 - The attitudes of patients and relatives
 - Different sub groups of nurses: the older nurses, the new to the profession , the international nurses and the community nurses

The advantages and attraction of another post

The first point to note is that participants were very conscious that nurses had choices in jobs in London. This was firstly because there were so many Trusts and health care employers in such relative proximity, unlike many parts of the country where there would be only one hospital in a town or region. Secondly the nurses had choice because the vacancy rate was currently very high and there were many jobs to choose from.

Nearly all the groups but particularly the newly qualified nurses offered that there were often 'good reasons' for leaving a post i.e. the new post had advantages to the individual nurse such as:

- a. increasing their experience ,skills , knowledge of other clinical specialities
- b. opportunities for training and development
- c. improved chances of a grade 6 career pathway
- d. better balance between work and life outside that
- e. promotion
- f. increased pay for a similar post in the NHS either graded differently elsewhere or on higher scale points
- g. higher pay rates for the same work as an temporary staffing agency nurse

A number of participants referred to the 'reputation' for high quality or clinically advanced services or hospitals as an important draw for nurses. Although the converse was also true for example a media report of bad quality services was reported to make a service unattractive to work in. Many of the ward managers offered the view that posts in London were often seen as a good '*stepping stone*' or '*finishing school*' to longer term jobs elsewhere for nurses newly qualified or early in their career. They noted that some movement in nurses was positive but that their Trusts needed to try and extend the length of time these nurses stayed with them.

Participants offered views as to what individual Trusts could do to retain these nurses. This included acknowledging that these were the factors drawing nurses to new jobs and try and address those so that the nurse stayed within that Trust. Suggestions included:

- Create an internal job rotation scheme for qualified nurses so they gained experience of different specialities or part of specialities in the same Trust ,
- Map out a pathway that led to progression to a grade 6 post , or the next graded post, within that Trust,
- Ensure the opportunities for training and development are articulated for every speciality and all grades in a Trust.
- Offer opportunities for short term project work for more experienced nurses looking to build a specialist or management career.

On the point of increased pay for a similar post in the NHS either graded differently elsewhere or on higher scale points, participants proposed London wide solutions to reduce competition between Trusts and employers such as: agreeing the same offer of training and starting salary for newly qualified nurses, agreeing the grading for the same types of posts, agreeing pay rates for agency nurses which were the same as NHS Professionals (the internal to the NHS agency for temporary staffing banks in each Trust).

We turn now to factors that were viewed as negative and more likely to 'push' nurses from their posts.

Negative factors pushing nurses from their jobs

Some of the participants commented that it wasn't usually one factor that made nurses decide to change jobs but a combination as in this example: *"you don't come into nursing for the money and you know you're going to work weekends but if you are given all rotas of shifts of evenings and weekends and the senior nurses aren't nice to you and you've no money to pay for a decent place to live on top of that – then you start looking at other jobs."*

Likewise some participants talked of the combination of factors that could overcome seemingly negative factors: *"you can put up with low pay and hard work if you are in a team which works well together with a good supportive manager"*. A number of ward managers advocated the need for good exit interviews with those nurses leaving to really understand the local issues and address them.

We look now at each of the negative factors in turn but note that they interlink. The ordering of reporting reflects the types of items mentioned first in groups but not necessarily the scale of their significance. The sub themes are:

- Remuneration and the cost of living ,
- Management practices
- The impact of nurse vacancies on other nurses
- Working patterns, patient acuity and staffing
- The attitudes of patients and relatives
- Characteristics of the nurses: the older nurses , the new to the profession , the new to the NHS, community nurses

Remuneration and the cost of living

Pay and remuneration was mentioned by all groups but they varied as to how important a factor it was in decisions to leave jobs – many thought it was a contributory factor but not the most important factor. ‘None of us came in for the money’. However there were two main issues around pay. Firstly, the high cost of living in London. This was felt to be a major factor in nurses’ decisions to leave their post, particularly in relation to finding affordable housing and child care. Many talked of nurses with families moving out of London for these reasons. Secondly, the decision by the government not to pay nurses and other NHS staff an increase in their salary to address the increased cost of living rises was pointed to as a key negative factor for many nurses. This was linked in some groups to the perceived unfairness of changes in the rules on annual increments.

Suggested ameliorating factors included:

- Trusts to have affordable accommodation for single nurses,
- Trusts being involved in key worker housing schemes,
- Using other ways of financially rewarding nurses for their contribution to a Trust such as retention or long service payments or 100% attendance bonuses ,
- Some Trust paid for staff social events e.g. an end of year party
- Other types of benefits such as reduced parking costs , help with child care costs, reduced membership fees to gyms
- Subsidised transport costs – “*the police get this -why not the nurses?*”

Management Practices

There was a view in many groups that ‘poor’ managers and ‘poor’ management practices contributed significantly to decisions to leave. In general the views of ‘poor’ in this instance were managers and management practices that: nurses felt unsupported and uncared for by, nurses perceived to involve inequitable treatment and application of policies between staff – creating a climate of ‘unfairness’ and at the extreme of this bullying behaviours by senior nurses to nurses junior to them. We describe these in more detail below. The issues of support and newly qualified nurses and international nurses are addressed separately in those sections below.

Some experienced nurses reported feeling unsupported by their managers in a) coping with high vacancies, b) in managing their workloads and expectations on them to mentor/develop others and c) in situations where patients and their relatives were challenging or making complaints. At the extreme of ‘uncaring behaviours’, there were described examples of bullying by senior nurses to those more junior. It should be noted this was not a widespread reported experience.

A lack of support and uncaring attitudes also linked to the perception of managers treating their nurses inequitably for example through having ‘favourites’. The inequitable allocation of unsocial rotas and shift patterns was often cited as example of this. Another example was the perception of agreement for some nurses to have flexible working hours but not others. Some participants viewed the solution as the application of human resource policies ‘fairly and squarely’ and that there was transparency and auditing in this.

Some nurses also pointed to underperforming nurses in a team as a factor and the failure of the ward manager to deal with this. Examples were given of nurses who were always late on duty, or called in sick frequently or *“hid out of sight not doing their share of the work”* so the rest of the nurses had to take a greater share of the work. Solutions were offered that the involved following human resource policies but some also suggested incentivising good performance e.g. 100% attendance bonuses.

Flexible working came up often as an area that could be source of tension in an ward or department if the balance wasn't right, *“if there are too many with flexible working in an area you end up with all those without young children having to pick up the nights and weekends- so they are the young ones who want a social life - and so then they leave – how do you balance all of this and run the ward?”*

Some nurses in a number of the groups discussed perceptions of inequitable treatment more broadly across organisations. Examples in some groups were of promotions not being fairly decided, although not all agreed. Some participants pointed to a lack of equality in opportunity for career progression for nurses from minority ethnic groups. Reference was made to the report in nursing journals of the ‘snowy white peaks’ of the NHS¹.

For many participants the solution to perceived unfairness, including bullying behaviours was the equitable use and enforcement of human resource policies. Participants commented it was not enough just to have these policies but they needed to be seen to be implemented and the implementation monitored.

Many of the nurses and ward managers and other nurses described what *‘good’* nursing management practices looked like. A ward manager described this as what made *‘nurses stick to you – they don’t want to leave’*. The aspects they described included:

- *“The small things that make a difference to the working day for a nurse”* –for example *“the thank you biscuits”*,
- Supporting individual nurses struggling to manage the work or who are distressed,
- Ward managers who were actively helping and managing the work , *“We have one manager who whenever she is on it does not matter what crises there are she always brings ease; another manager brings stress before the day has begun”*,
- More senior managers who were visible to and engaged with the ward nurses *‘Dropping in to help for half an hour occasionally when they knew staff were short in an area would mean so much’*,
- Listening to the nurses, involving them in problem solving and finding ways to introduce solutions to make their work environment and practices better. Examples were given such as introducing new low technology equipment for each bed so the nurses weren't walking around the ward trying to find the equipment,
- Finding creative ways to help nurses develop their careers even in the face of limited training budgets, examples were given such as giving different responsibilities to all the nurses on the ward such as link nurses for infection control, or lead for education.

¹ Kline R 2014 The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. <http://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf>

- Creating good working relationships amongst the team members,
- Make sure the rotas are fair to all nurses and agree flexible working hours according to the hospital policy,
- Understanding and applying all the Trust policies fairly and making sure the nurses understand those policies,
- Giving recognition and positive feedback to those doing a good job and not allowing nurses *“not pulling their weight “* to think that was acceptable ;and *“being clear what is expected of the nurses on my ward”*,
- Having control of a devolved budget so that the ward manager could adapt and change the skill mix on the ward, increase administrative support or make small equipment purchases to improve the ward environment for patients and nurses. *“We don’t have any more money but it has made a real difference having some say in how we spend it”*.

Many of the participants supported the idea that nurses needed to see a career pathway in their Trust into management roles. There was a wide spread view from Band 6 nurses and ward managers that their Trusts need to invest in leadership or management training for nurses at all grades *“which helps the service but keeps those nurses too”*. Some participants observed that there should be more attention paid to rates of leavers or retirements from ward managers’ posts as they considered there *“was little appetite for this type of management job”*. They thought Trusts should be doing more to succession plan and actively train nurses for those roles. One participant observed that one of the inhibiting factors for nurses to take those management roles is that they lost unsocial hours payments so they were not financially better off for greater responsibilities.

The impact of nursing vacancies

A full staff compliment and good team working was described as an important factor in managing the demands and stresses of the job, *‘If you work as a team everything is easier’*.

Many groups talked about the impact on ward nursing teams of high vacancy rates. The consequences were that there was increased use of temporary nursing staff – mostly from external agencies, although some Trusts had their own banks of temporary nurses. Participants cited examples as to how use of agency nurses would then affect the permanently employed nurses - they would have to cover more work or take more responsibilities as these agency nurses were unfamiliar with the ward routines, patients, environment, and hospital policies. In turn this added to the work for the permanently employed nurses who then started to consider leaving. *“It’s frustrating and stressful not to be able to do the job you want to because of staff shortages”* Participants also cited how hospital policies meant agency nurses could not undertake work expected of qualified nurses such as administer medicines as they had not been assessed as safe by that Trust. It was apparent from the discussions that some Trusts had found a mechanism to ensure agency nurses had had an assessment of clinical safety.

Some participants also pointed to a perceived unfairness between themselves and the agency nurses in terms of pay and responsibilities , *“ you know they [the agency nurses] are being paid more than you but you are having to do more work – they are being paid for turning up and doing little“*. The issue of higher pay rates paid by agencies to temporary nurses was raised both as an unjust situation

but also as an attraction to leave posts. Some ward managers discussed another negative consequences of having to employ agency nurses in that they gave direct information to their permanent nurses and acted as *'recruiting agents for the agency.'*

High vacancy or staff shortages was also reported to result in permanently employed nurses being asked at short notice to work in unfamiliar wards or departments other than their usual place, this too had consequences *" they [the nurses] don't like to be moved about – it adds to the feeling of dissatisfaction "*.

The types of solutions participants suggested to this problem were mostly linked to efficient and timely recruitment procedures as well as better retention. Some questioned whether there was more that could be done to improve the speed of the recruitment processes , given the known difference in notice periods and recruitment periods *" one month's notice –months to get someone new in [post]– and then they need induction time . "*

Some participants also offered the caveat that even though there might be a pressing need for recruitment of permanent staff, standards of recruitment should not be lowered as this could have a longer term negative effect. Low performing team members were reported as having a really negative influence on the nursing team and took much effort to remove. *"Better to operate for a bit longer understaffed than appoint someone unsuitable"*.

A number of participants also pointed to the negative consequences of *"empty promises"* included in generic nurse recruitment from Trusts. Examples were given where the recruitment materials promised opportunities for going on courses. In reality on a ward team this was subject to availability, budgets and how many other nurses on the team were already released to attend courses. This was reported as a disappointment to the recruited nurses who then looked elsewhere and a challenge for individual ward managers to manage expectations and remain consistent with hospital policies.

Linked to this was the impact of continually bringing in new nurses and the linked induction and training period. Participants pointed to the challenges posed by Trust specific centres for assessment of clinical skills and safety such as medicines administration or training for skills not included in the basic training such as venepuncture and the administration intravenous medicines. This was reported to result in qualified nurses unable to undertake those duties often for months (one example was given of seven months) while they waited for a date at the assessment centre. Participants described the consequences on the rest of the team and suggested that more assessment of clinical safety could happen on the ward or in different ways.

Working patterns, patient acuity and staffing

Participants repeatedly referred to the shift patterns, unsocial hours and little opportunity in flexibility of working hours as one of the factors in making nurses consider leaving. Specific working patterns were considered to be unfavourable viewed by many such as *'internal rotation'* i.e. all nurses employed in that team have to work some night shifts over a defined period as well as day time. Some participants considered that those newly qualified started their posts with little real understanding of what working shifts meant (see the following section with regard to newly qualified nurses). Flexibility in shift hours was seen as important for those with caring commitments

– as family carers of other adults with disabilities or illness as well as of children. All of the Trusts had policies on flexible working and , for example , some were reported to offer term time contracts for those with school age children. The issue of how these policies were applied is dealt with in management practices above.

Experienced nurses thought that there was increased complexity in the patients who were inpatients that contributed to the physical and emotional heaviness of nursing. Some thought this added to the job satisfaction but others through the context was important here *“you might enjoy the challenge of a complex patient condition if you are in ITU or trauma but not when you have a ward with 17 other patients”*. Some cited particular areas such as care of elderly and orthopaedics as particularly heavy and less attractive. They argued for a different or higher ratio of staff on those types of wards compared to some others to make the work manageable. Ward managers stressed that the right staffing levels and the right skill mix (including administrative staff to support increasingly amounts of ‘paperwork’) was critical to manage the types of patient acuity.

One group of nurses also argued that hospital wide changes to systems, such as patient records which had a significant impact on their working practices, were imposed without enough consultation with the nurses who would use them. Consequently these types of changes added to the workload which could have been avoided. They pointed to the importance for nurses to feel they were involved in decision making in the organisation not just imposed upon.

Attitudes of patients and relatives

A recurring theme in most of the groups was the impact on nurses of not being valued by patients and relatives and more widely the public. Participants talked about disrespectful treatment by patients and relatives, as in *“demanding patients who treat you with little respect”*. In some groups there was quite a strong feeling that nurses are treated with disrespect now in a way which did not happen previously. *“We have some newly arrived Portuguese nurses and they are shocked at the way we are treated”*. This was seen as partly due to negative media coverage. Younger people and relatives were seen as particularly aggressive and demanding. This was reported to add to the stress of the work and be particularly difficult for younger and junior nurses. Some participants talked of increase in knowledge brought about by the internet combined with a change in culture towards health care provision in the UK. *“There has been a change of culture. People now arrive having researched on the internet and want to challenge, or threaten to sue”*

Potential solutions were offered that linked to management practices such as supporting staff reported above and the full use of policies such as those on patient complaints and challenging patients.

Different sub groups of nurses: the older nurses, the new to the profession , the international nurses and the community nurses

Age was raised as a factor in only one group. In particular, older nurses who were described as *“worn out tired and fed up”*. The suggestion was offered that to retain these nurses in the workforce *“sabbaticals”* could be offered whereby they could be offered time out or release from their job to undertake a specific piece of work needed by the Trust. This was not a group purposively sampled and was perhaps an omission in the study.

Much more time was devoted in the groups to the experience of the new to nursing or newly qualified nurses.

Ward managers were keenly aware of the *'first shock'* and *'scariness'* of the reality of working for those newly qualified nurses. They described them as being very vulnerable to leaving their jobs and posts. They were aware that the first experience over six to nine months could *'make or break'* them as to whether they remained working as nurses or left the profession. They pointed to the solutions being in good management practices (above), good orientation and induction, a good preceptorship process, enough mentors and practice development nurses on the wards to support them and enough permanent staff. Some more experienced nurses offered the view that there might be increasing attrition in those new to nursing as *"they come with different expectations as to what nursing in a hospital is like from those in the past"*. Some argued that the training meant nurses had no loyalty or identification with a particular hospital or Trust as they had in the past. Some ward managers described nurses, particularly early in their career, as thinking that *'the grass is greener'* on another type of ward or department but then found it was different but equal work. Suggested solutions included changing the clinical element of their training so it better prepared newly qualified nurses for the *"reality of the work."*

The newly qualified nurses themselves pointed to combinations of factors being likely to make nurses leave rather than one *;" you know you are going to be new and having to learn , working shifts and that , not great money for London , then you find the shifts are short staffed , you're working with agency nurses who won't do things , relatives start complaining , someone is not nice to you ...and then on top of that you're given a rota with all nights and weekends – it's that one extra thing on top of the rest"* .

The newly qualified nurses identified all the range of factors cited in the previous sections but also: the lack of support, recruitment promises of support (e.g. by practice development nurses) and courses/induction which did not materialise as well as the issue of having to wait months for in-house training and assessment of certain types of work. Some felt this meant the other nurses saw them as not *'pulling their weight'* and then acted negatively towards them. This is a point raised above in relation to compounding staff shortages as colleagues then have extra work to do. As mentioned above this seemed like a problem that could be addressed by considering different forms of training or as one newly qualified nurse said *"Couldn't they just give us all the training we need before we start on the ward or as our induction?"*

Being treated inequitably compared to the more experienced nurses was also a theme for example with regard to shift patterns. Some of this group also talked about not being treated *'kindly'* by more experienced and senior nurses. Their solutions mirrored that of the ward managers and that discussed in the management practices. They also argued it was important to make sure they had *" someone to turn to "* as well as structured induction programmes for their ward area which included all the additional training or assessment they were required to have.

The international nurses who were new to the English NHS came from a range of countries that were close to England, such as Ireland, a few hours flight away, such as Spain, and long haul flights away, such as the Philippines. Given this was a group willing to work away from their home country some referred to the attractiveness of other countries to work in comparison to the UK which would draw them to leave. Factors included better pay and conditions, guaranteed longer term accommodation,

greater proximity to their home country as well as more helpful entry requirements making visits or residence for families easier.

These international nurses gave all the issues raised in the sections above and similar solutions. In addition they pointed to their need to be inducted and understand health care in the UK and the NHS. A particular issue raised was the lack of demarcation they observed between the work of the health care assistants and that of the qualified nurses in England. They found this a problem and something that might contribute to nurses leaving. A further issue was the policy which insisted on hospital training and assessment for certain clinical procedures which some of the nurses reported was in their countries basic nurse training but not recognised here. Some talked of their frustration and demoralisation at not being allowed to 'nurse' as they saw it.

A number referred to homesickness as an issue. For some this was compounded by the lack of empathy they experienced from ward managers and other nurses with regard to their newness to the work, being in a foreign health care system and a foreign country " *I don't understand why she [the ward manger] isn't a bit nicer, she could be kinder, she can see how nervous I am.*"

We interviewed only one group of community nurses and so can be less certain that their views reflect others. In the main the issues and solutions they raised mirrored the hospital nurses in terms of: cost of living and pay, inflexibility in shifts and unsocial hours, high vacancy rates impacting on workload, increasing levels of paperwork through defensive practices, lack of opportunity for development and promotion (particularly they thought in comparison to hospital nurses) and perceived lack of support from senior nurses. They also thought that they were not highly regarded by hospital staff. They cited examples of hospital staff not recognising the community nurse skill or understand the circumstances they worked within – leading to patients being discharged from hospital who needed community nursing input but with no regard as to whether that was possible. Issues around the costs of car insurance, availability of parking permits, the congestion charge were raised by some but others in the group pointed out these were misunderstandings on the part of the nurses who raised them. The nurses thought their lack of opportunities to learn, meet or socialise together was a factor in making community nurses leave and something that could be addressed by team events such as away days to look at service issues and social events such as Christmas lunches.

6.3 Concluding comments

These interviews reflect the views from nurses delivering patient care across South London. There was great consistency across the groups and the nurses in the issues raised and solutions proposed concerning remuneration and the cost of living, management practices, the impact of nurse vacancies, working patterns, patient acuity and staffing and the attitudes of patients and relatives. Some solutions may be beyond individual Trusts, such as NHS pay levels, but some solutions were proposed at the Trust, division, ward and team level. These might offer insights that could be used by groups and individual managers to test their practice and services against. Fundamentally there are many job choices for nurses in London, the UK and globally – and many nurses move for the attractiveness of the other post in comparison to their own. While, as many acknowledged, it is good to have some movement bringing in new people, the challenge for London Trusts is get to the optimum point in retaining nurses in their posts and organisations. Many of the solutions resided in good management practices and implementation of the human resource policies. Given the layering of factors that were thought to influence the decision to stay or leave – perhaps the following are

ones that make the tipping point and could be addressed: perceptions of equitable treatment with others, being engaged and involved in decisions, being valued as a team member, being supported and praised and simply being treated kindly.

References

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